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THE MEDICAL AND SURGICAL REPORTER.

No. 1888.

PHILADELPHIA, MAY 21, 1892.

VOL. LXVI—No. 21.

CLINICAL LECTURES.

CARDIO-VASCULAR GRIPPE.*

By H. HUOHARD, M. D.
PARIS, FRANCE.

A CLINICAL LECTURE DELIVERED AT THE
HÔPITAL BICHAT.

Gentlemen :—I have, in a previous lecture, described the different manifestations of cardiac grippe, especially with reference to the action of the poison upon the endocardium, the pericardium and the myocardium. I have not, however, as you will see, exhausted this interesting subject, and I have endeavored to show you that in this disease, the nervous system, more than in any other infectious disorder, is profoundly affected.

MEDULLARY AND VAGO-CARDIAC GRIPPE.

The grippal poison acts upon the nervous mechanism of the heart through the medulla oblongata and the pneumogastric nerves, the functions of which are often greatly disturbed. I will not speak of the intra-cardiac ganglia, the normal anatomy of which is more or less obscure, and the lesions or functional disorders of which, likewise, belong generally to the domain of simple hypotheses.

I have for a long time been struck, especially during the epidemic of 1889-1890, with the lack of concordance in certain grippal pneumopathies existing between the relative benign character, the slight intensity of the lesions, and the gravity of the dyspnoic symptoms. Thus you have observed patients presenting only a few sub-crepitant râles over the chest succumb to an acute attack of asphyxia. At other times, these signs have accompanied

pulmonary congestions of hæmoptoic form, attended with true and quite abundant hæmoptysis, which have terminated in death of the patient within a few hours. Still in another class of cases, the pulmonary congestion is slow in its development; it is sub-acute, resisting, during weeks, all therapeutic treatment. Finally, you have seen the occurrence of a super-acute œdema of the lung accompanied with a kind of albuminous expectoration and a most dreadful dyspnoea to which patients rapidly succumb.

In the course of these various complications, the pulse is sometimes unusually rapid, or, on the contrary, abnormally slow. Again, in certain cases, the gastric phenomena (incessant vomiting, acute dilatation of the stomach, etc.) exhibit a most serious character. The three branches of the pneumogastric are affected, and it is not enough to say with Vovart, that the grippe is particularly characterized by "a neurosis of the vagi," it must be said especially that these nervous manifestations are of a paralytic character. In influenza, let me repeat, the pneumogastric nerves appear as if they were severed, and thus the various congestive phenomena of the lung may be explained, phenomena which I have spoken of as "pulmonary paralysis." These conditions were recognized by Graves, and I, myself, have studied them under the name of *bronchoplegia*. In these cases patients die from being literally asphyxiated, but they may likewise succumb very rapidly under various symptoms of heart paralysis, of *cardioplegia*, since the cardiac branches of the vagi are the ones principally affected.

The disease, whose poison is carried to the whole nervous system, may particularly alight upon the medulla oblongata. This *bulbary* or *medullary* form is quite frequent. I called attention to this point three years ago, and thereafter other

*See issues of the REPORTER of April 9 and 16, 1892.

authors have published cases similar to those I, myself, have described. Lately, Kelsch and Antony (*La Grippe dans l'armée Française* in 1889-1890) have said that the peculiar affection of the medulla is not of rare occurrence in the Army, and that it has usually made itself manifest by symptoms of syncope and lypothemias. I have, myself, observed a medullary phenomenon *par excellence*, that is, the Cheyne-Stokes respiration, and this in the absence of all renal lesions. Finally, we can refer to the medulla many cardiac symptoms dependent upon a disturbance of the functional activity of the vagi, such as *tachycardia*, *bradycardia*, certain phenomena of *cardiac collapse*, *cardiac-taxis*, and *cardioplegia*; those dependent upon paralysis of the lungs and bronchi (*bronchoplegia*), and the oedemas, or vagoparalytic pulmonary congestions; as also certain super-acute emphysemas. It is important to be acquainted with this medullary form; to this have been due the rapid or sudden deaths reported by almost all the ancient historians of the disease in question.

I have, myself, reported many cases of this nature to the Société Médicale des hôpitaux (*Soc. Méd. des hôpit.*,) January 24, 1890), some of which are as follows: One of our lamented country colleagues died in the following manner: He was suffering from a slight bronchitis; from time to time he would be taken with marked attacks of suffocation, which would be brought on even by slight exertion; the pulse would become accelerated, the patient being threatened, at every moment, with syncope. He died suddenly through failure of the heart, after many lypothemic attacks, without there being anything to announce such a brusque termination. Another patient exhibited simply symptoms of an infectious gastric embarrassment. He died from syncope, notwithstanding that auscultation had revealed nothing abnormal. A man, 60 years of age, had all the symptoms of a gastric trouble, which rapidly assumed an infectious character, and the general prostration was so marked that the attending physician believed it to be the beginning of an enteritis. (I have often showed you, during the epidemics of 1890 and 1891, cases of this grippal *pseudo-typhoid* through which errors of diagnosis have been made). This patient had a cerebral

excitement with an irresistible tendency to somnolence; a little albumen was found in the urine, and over the base of the right lung, small, fine râles, indicative of pulmonary congestion, were noticed. Finally, there appeared in a rapid manner, arrhythmia, and attacks of cardiac intermittence, this latter phenomenon being definitely established later. One night death was imminent; the pulse was weak, compressible, filiform, and became better only after many hypodermatic injections of ether and caffeine. On the following night, the patient was threatened with cardiac collapse. During a whole hour the pulse was weak and could hardly be felt under the finger, the fluttering condition of the heart being quite noticeable; the extremities became cold and cyanosed, the skin covered with a cold sweat, and the patient was thrown into a state of lypothemia and continued somnolence. In one word, it seemed as if death would occur at any moment, and, therefore, I gave, one after another, five subcutaneous injections of ether and caffeine. An hour later, the pulse recovered its force and regularity, and by next morning, all these symptoms had disappeared. On the reappearance of these serious symptoms the injections were resorted to with the same happy results.

You see, then, that therapeutics is not entireless powerless, and in order to treat such symptoms with higher probabilities of success, it becomes necessary that we should be thoroughly acquainted with them.

CARDIO-VASCULAR AND VASCULAR GRIPPE.

a. The *pulse* often presents that character which I have spoken of as unstable. Such phenomenon consists in this: From the moment that the patient passes from the horizontal to the vertical position, that is when he sits upright, the pulse becomes accelerated, going up as high as 80, 120 and even 130 per minute. This is a sign of cardiac weakness and of depression of the arterial pressure, and is especially observed during convalescence. It must not, however, be confounded with the unsteady pulse described by Graves in the following terms: "The pulse rarely exhibits identical characters. You will find it rapid and hard; 6 hours later it will be rapid and soft, and later still, after 6 or 8 hours more or less, it will show a normal frequency;

but by the following morning it will have become quick and jerky. . . . But the most remarkable fact is that towards the end of the malady, the pulse sometimes becomes full, strong and vibrating, and this is observed upon individuals who have suffered for whole weeks."

In the course of the various pulmonary manifestations (pneumonias, bronchopneumonias, etc.) the pulse frequently exhibits a rapidity proportionate to the height of the febrile movement. Yet, at other times, an absolutely opposite phenomenon is observed, the cardiac beat being relatively slow, which is in great part due to the medullary or bulbary disturbances.

This relative *brachycardia* did not escape the sagacious observations of older authors. Thus in the epidemic of 1837, according to Landau, "the pulse, ordinarily large and full in this disease, was small and slow, and except in two patients in whom it attained a rapidity of 82, it did not go beyond 72; generally it varied from 60 to 68." Valleix, who has generally held a contrary opinion, is forced to admit that "the pulse appears to have less amplitude. . . . Its acceleration does not, in the majority of cases, bear any relation to the violence of the febrile symptoms." This is a fact which has been noticed in quite a large number of cases, and which pleads in favor of the action of the grippal poison on the pneumogastriacs.

From this point of view there is one disease which resembles influenza, and that is, typhoid fever, characterized, as you well know, by a relative slowness of the pulse, which is at the same time a favorable prognostic sign. Typhoid fever, likewise, resembles influenza in its action upon the arterial contractility, and, similarly, in the considerable diminution of the vascular pressure.

b. Condition of the arterial pressure.— You already know that typhoid fever is characterized by a low arterial pressure, this being one of the chief causes which produce in this disease the formidable syndrome known as *embryocardia*. Again, my numerous researches regarding the state of the arterial pressure, have shown that ordinarily there is in influenza a considerable diminution (*Soc. Méd. des Hôpit.* March 14, 1890); hence, *embryocardia* is not rare in this affection.

This embryocardiac syndrome studied by Stokes under the name of "foetal rhythm of

the heart-beat" but which does not appear to comprise its pathogeny nor its prognostic importance, is due, according to my investigation, to the extreme lowering of the arterial pressure and to the weakness of the heart. It is characterized by 3 fundamental symptoms: 1, *tachycardia*; 2, equalization in the duration of the two pauses; 3, a similarity in the thrill of the two sounds. Thus, the embryocardiac beats resemble those of a pendulum, or those of a foetal heart. Again, the appearance of this sign has a great prognostic importance, as it may sometimes announce the fatal termination of the malady in a longer or shorter period, if a remedy is not promptly given. The best medication consists in the administration of remedies that constrict the blood-vessels and elevate the pressure, such as ergotine and caffeine. I have observed this syndrome in many cases, during the course of the disease and even during the period of convalescence. It will be sufficient to report the following instance: A patient, 51 years of age, suffering from the grippe, was suddenly attacked by cardiac symptoms: pulse feeble, almost imperceptible, and difficult to count (160 per minute); sensation of retro-sternal constriction and constant oppression; cyanosis of the hands and extremities; coldness of the surface; a precipitated action of the heart, the beats, 200 per minute, being equal in thrill and intensity, separated by the pauses of absolutely equal duration (*embryocardia*). The patient died 40 hours after the onset of these symptoms; there was no elevation of the temperature; on the contrary, there was a quite marked tendency to a diminution of the bodily heat.

Embryocardia is sometimes the precursory phenomenon of *cardiac collapse* to which the patients rapidly succumb.

c. Grippal arteritis and phlebitis. Do the arteries suffer directly under the influence of the grippe, in other words, is there such a thing as a *grippal arteritis*? The question remains *sub judice*. I will, nevertheless, bring to your notice the fact that in an autopsy I have found an obliterating inflammation of the coronary arteries. On the other hand, Rendu has recently reported a case of gangrene (*Soc. Méd. des Hôpit.*, January 15, 1892) of the extremities, after an attack of the grippe. But, as has been observed by Netter an arteritis may be found in the neighbor-

hood of a clot, and here again we have an analogy with the condition met with in typhoid fever.

A fact which I have observed and which was not unrecognized by the older historians of the disease, is that pertaining to the great frequency of *cerebral hæmorrhages* occurring during the course of an epidemic. I do not pretend to say that the gripe *per se* is capable of producing this accident; but I cannot help believing that the malady in question enhances the rupture of the miliary aneurisms of the brain.

Grippal phlebitis is better demonstrated, of which I, myself, have observed four cases. In this respect I will recall the case of double phlebitis of the inferior extremities occurring in a boy-patient, following an attack of the gripe, and which was complicated with serious symptoms of pulmonary embolism. My colleague, Fermand, has, likewise, reported two cases of phlebitis of the lower extremities, this condition occurring after an attack of influenza (*Soc. Med. des Hopit.*, March 14, 1892).

d.—Action of the gripe on cardiopathies. This is another category of the action of the disease, that deserves your most serious attention. I have often spoken to you about the chronic maladies aggravated by influenza, and of the kind and amount of aggravation of such maladies. I have shown you a large number of valvular affections of the heart in which the rapid aggravation could be dated from the very day that patients were attacked by the gripe. From that time, the cardiopathy, compensatory or latent, rapidly arrives at a hyposystolic, and at the same time at a definite asystolic period. An explanation of this is found in the tendency of the gripe to diminish the arterial pressure. Again, you know that the lack of compensation in diseases of the heart is due, in great part, to the lowering of the arterial pressure, and you can understand why influenza, bringing about an asystolic condition, rapidly aggravates a pre-existing cardiopathy, and it does so more readily than through an influence on the nervous mechanism of the heart.

This aggravating influence is also exercised on arterial cardiopathies. In three cases of angina, the sternocardiac crises were quite frequent and severe. In one case, laboring under an interstitial nephritis, an attack of influenza produced a rap-

id fatal termination through a sub-acute cedema of the lungs. In one word, arterial cardiopathies are evolved with marked rapidity, and appear as complications of arhythmia, cardiac intermittance and cardiac asthenia. I have seen a large number of cases of arterial sclerosis of the heart, which, while latent from a symptomatic point of view, were made manifest after an attack of influenza under a persistent arhythmic form. On the other hand, in the absence of all lesion of the myocardium or of the valvular apparatus, or by virtue of a simple functional affection, the arhythmia may appear suddenly during the course of the malady under consideration or during the period of convalescence, remaining then as a permanent symptom.

An interesting case has been reported by H. Blanc (*L'arteriosclerose en general et les scleroses vasculaires dans l'armee, Arch. de Méd. Militaire*, 1891) which sustains what I have said regarding the aggravating influence of the gripe on arterial cardiopathies. It is as follows: A soldier exhibiting all the appearances of a perfectly healthy individual, suffered an attack of grippal broncho-pneumonia. After his recovery he continued to suffer from dyspnoea; on examination there was found a marked systolic murmur over the third intercostal space of the right side. At first it was thought to be a simple extra-cardiac murmur; but three months afterwards, the diagnosis of an arterial cardiopathy was made. Here was a patient without any renal or pulmonary trouble, and in whom the orifices of the heart were healthy; the symptoms came on after an attack of the gripe and the slightly perceptible hypertrophy noticed at first, had become more and more marked. Here, then, the relation of the cardiac affection to the gripe was quite clear.

However, it is only late, that is, after a year or two or perhaps many years, that cardiac symptoms following an acute infectious malady are made manifest. This shows that the effects do not always immediately follow the causes which produce them. If after an attack of influenza, typhoid fever, small-pox, scarlatina, etc., you do not find any trouble in the heart during the march of the disease or during the period of convalescence, you must not, however, neglect to practice cardiac auscultation. The lesions following these various affections may remain latent for a

long time; they may require months or even years to make themselves manifest; and many times you may and will meet with aortic insufficiencies the etiology of which you are at loss to account for, and this because you have failed to recognize the influence that any one of the infectious diseases referred to may have exercised.

If coronary endocarditis of grippal origin really exists, of which I have had occasion to show to you one example, you can understand why it remains latent until it alights upon the cardiac muscle to produce degeneration. You would be wrong in dating from this day the appearance of the cardiopathy, and you see the importance of not confounding the *apparent* with the *real* beginning of a disease. Inflammation of the coronary arteries may commence and has commenced during the march of the affection or during the period of convalescence from the grippé; the lesion progresses in a quiet manner undetected by your ear; and the consequent degeneration of the myocardium is at last made apparent by a marked symptomatology. Bouchard has remarked: "The infectious diseases produce often tardy consequences. While the pathogenic germ may be destroyed, the disease is not at an end; man continues under its influence, and after a long time, it appears in certain tissues and apparatuses through lesions which are the expression of a tardy disturbance of nutrition brought about by an infectious malady."

s.—Grippe and rheumatism.—According to my observations, rheumatic troubles are of frequent occurrence during and after epidemics of influenza. This fact has not escaped the notice of ancient authors and thus Lancisi who has wrongly assimilated, so to speak, the two affections, has given to influenza the name of *rheumatic fever*.

I have observed two cases in which an acute articular rheumatism was developed during the course of influenza and during the convalescence from the disease. In the first case I noticed the coming of an endopericarditis which could be attributed to rheumatism and not to the grippé. This is a source of error to which I desire to call your attention; you must not attribute to the grippé an endocarditis which is dependent upon a rheumatic affection. Let me remind you of the fact that influenza, more than upon the endocardium

and pericardium, it exercises an action on the nervous mechanism of the heart.—Translated from *Le Bulletin Medical*, March 13, 1892.

ALLEGED SYPHILITIC INFECTION BY INSTRUMENTS.

BY G. FRANK LYDSTON, M. D.,
CHICAGO.

PROFESSOR OF DISEASES OF THE GENITO-URINARY SYSTEM AND SYPHILOLOGY IN THE COLLEGE OF PHYSICIANS AND SURGEONS.

Gentlemen:—The first case which I present to you this morning is one of unusual interest, involving as it does certain interesting clinical features of syphilis and some points in what might be termed the jurisprudence of syphilis.

The patient, a woman of about 40 years of age, who, as you see, is a stout, healthy looking individual, was referred to me by a prominent physician as a case of syphilitic infection probably due to unclean instruments in the hands of a respectable practitioner of this city. The woman gives a history which, taken in connection with her present condition, most effectually proves the error of the charge against the doctor by whose unclean instruments the case was supposed to have been infected. This is a matter of congratulation, as the patient herself has apparently been very acrimonious and disposed to make trouble for her physician.

The history of this patient is as follows: Six weeks ago she consulted her doctor for treatment for a sore throat, which had then lasted about a week. The doctor, she claims, told her that she had pharyngitis and enlarged tonsils and made some applications to her throat, using as she expresses it "an old brass thing," which hurt her tongue and made it sore for several days. One week later she says she noticed an eruption upon her body. She denies any local trouble and declines any examination. She says that she has had absolutely no exposure to possible venereal infection. On examining the face, you will notice a distinct erythema involving the nose, the inner aspect of the cheeks, the lips and the chin. On palpation I find this erythematous area to be slightly raised from infiltration, the skin

being slightly stiff to the feel. There is no tenderness and no heat in the parts. Here and there upon the face we observe an eruption of papules, some few of which are scaly. I find upon the scalp papulopustular and papulo-crustaceous syphilides. Just at the roots of the hair and extending down for a few lines upon the forehead you will observe a crown-like and symmetrically arranged series of distinct rows of papules, presenting the characteristic livid red color of the syphilide. Upon the neck and chest we observe a fading macular eruption, the *rosola syphilitica*, interspersed with papular and papulo-squamous lesions. Upon the palms are found scaly papules, and the patient claims that similar lesions are present upon the soles of her feet. We will now proceed to examine the mouth to see if we can find anything suggestive of a chancre. On careful inspection I fail to find any vestiges of what might be even suspicious of an initial lesion either in the mouth or pharynx, or upon the tongue. I find at the base of the tongue at the point where the patient seems to believe infection occurred, a characteristic mucous patch, in no wise different from a number of others upon the tongue. I observe several rhagades or fissures upon the sides of the tongue. There is a liberal supply of mucous patches upon the buccal mucous membrane and several in the larynx, the tonsil upon the right side containing one of good size. The fauces and pharynx present the characteristic appearance of a syphilitic sore throat. You will notice that the left eye presents a redness of the conjunctiva and the patient claims that it is very sensitive to light, and that she has had considerable pain in and about the eye for several days. I find on examination that the pupil is sluggish in its reaction to light, and that the iris appear a little swollen and cloudy and of a more grayish color than natural. We have, in other words, characteristic evidences of syphilitic iritis. The *ensemble* of lesions in this case presents as pretty a picture of marked early secondary syphilis as could be wished. We will now dismiss the patient and proceed to consider the merits of this case.

To the uninitiated the history of this woman, as she gives it, might seem to have a very important bearing upon the professional skill of the physician whom the patient accuses of infecting her with

syphilis. Fortunately for the medical profession,—and sometimes for accused individuals among the laity,—syphilis is a disease which has a very typical and reliable course of evolutionary progression. The fact that this woman has had this eruption for four weeks proves conclusively that the accused physician could not possibly have infected her at the time stated. As this physician had not treated her throat before, his innocence is thoroughly established. Wherever the location of the primary lesion may have been in this woman, said primary lesion must have antedated the appearance of the eruption several weeks; in all probability, at least four, and more likely six or eight weeks. There is little doubt in my mind that the eruption existed upon her body prior to the time she states and was probably present at the time she consulted the physician for sore throat. That sore throat was in my estimation syphilitic, and in all probability the inconvenience that the patient experienced from the use of the tongue depressor at the hands of the physician was due to irritation of the already existing mucous patch upon the base of the tongue. Of course, at this late period there would be little likelihood, even though infection occurred in the manner stated by the patient, of my finding remains of a chancre in the mouth. Still, as the woman has not been properly treated, and there are present in the mouth all of the conditions essential to the protraction of irritation, it would be by no means surprising,—admitting that infection had occurred in the mouth,—for us to find at the present time chancrous erosion or ulceration. If a characteristic chancrous lesion were found, it would show at least that the infection did occur via the mucous membrane of the mouth or tongue according to the situation of the sore. The presence of a chancre wherever found would not, however, change my opinion in the least as regards the date of infection. This woman was probably infected in the good old fashioned way some twelve weeks or so ago.

I wish, gentlemen, to call your attention by means of this pertinent illustration to the necessity in cases of syphilis of obscure origin, or cases in which an accusation is made against a physician of having produced syphilitic infection by means of unclean instruments, of studying carefully the natural history, the characteristic

evolution, so to speak, of alleged vaccinal syphilis. The physiological disturbance incidental to the febrile reaction from vaccinia sometimes brings to the surface dormant syphilitic conditions, and the practitioner performing the operation of vaccination might possibly be given a great deal of annoyance, or even have his reputation seriously impaired by the accusation of having infected the patient by impure virus or an unclean syphilized lancet. If the physician can prove unequivocally that he used bovine virus, and if he can show that he has performed his scarification with the ivory point itself, he has a pretty clear case, otherwise there is a certain element of insecurity in his position. If immediately following the vaccination, i. e., within a few days or a couple of weeks or so, a generalized eruption occurs, even admitting this eruption to be of a syphilitic nature, it cannot possibly be due to infection during the vaccination, for there is a distinct incubation period following the introduction of the syphilitic poison before the local sore appears, and another apparent period of incubation—the so-called secondary period of incubation, intervening between the appearance of the chancre and the development of a generalized eruption. Within certain limits this division of the evolutionary course of syphilis into periods of some weeks duration is very arbitrary. In order to prove infection at the hands of the physician it must be shown that a local duration or some peculiar transformation of the vaccinal vesicle has occurred, appearing on the average 21 days after the operation of vaccination, this being followed by a period of quiescence of on the average six weeks duration, which period of quiescence is succeeded by general manifestations of syphilis. Then too, the character of the lesions in alleged cases of surgical infection with syphilis is very often significant. If, for example, a child after vaccination, or a patient after a surgical operation, should develop within a few weeks bone or periosteal lesions, or any of the various phases of gummy deposit characteristic of late syphilis, it would certainly throw the case of infection on the part of the physician out of court.

Note.—I have since corresponded with the gentleman whom this woman accused of having infected her by means of unclean instruments. I find that the woman is the proprietress of a disreputable lodging

house run for the benefit of *nymphs du pave*, and that while she had no generalized eruption as far as the doctor knows, she was suffering from mucous patches upon the tongue and tonsils at the same time he made his applications. The physician is one of our most competent practitioners.

CONCEALED CHANCROID WITH SLOUGHING.

The next case to which I will call your attention is a young man who has been suffering for some weeks with some trouble with his penis. He states that four or five days after suspicious exposure he developed several small ulcerations, upon the penis apparently from his description situated just back of the corona glandis. Within a few days the prepuce, which was always redundant and retracted with difficulty, became greatly inflamed, and he found that he was unable to retract it. The inflammation and swelling have gone on until to-day you notice that the prepuce is very much elongated and swollen and on pinching it up between the thumb and fore finger, I find that it is quite hard in consistency. Issuing from the preputial orifice, you notice a thick, greenish, extremely virulent looking purulent discharge. On the superior surface of the prepuce just over the glans, you will notice a discolored area in the middle of which there is a ragged, irregular opening. This is the first beginning of sloughing of the tissues of the prepuce. Evidently a spot corresponding to this aperture has become gangrenous and has sloughed away, leaving an ulcerated and sloughed area of tissue behind it. I have no doubt that the test of auto-inoculation would show conclusively if we cared to wait two or three days for this evidence, that we have to deal with here a case of concealed chancre. The history of the case, however, and the appearance of the parts are sufficient for a diagnosis. Now, the question arises; has this patient true syphilis? Without an inspection of the parts it would be impossible for any one to pass an opinion upon this point. Even upon inspection it might be impossible to say at this early period whether the patient has syphilis or not. I find upon inspection of the groins a well marked bubo upon each side. There is yet no fluctuation, but from the diffuse character of the inflammatory glandular swelling, the dusky appearance

of the skin over it and the extreme tenderness of the part I can safely predict that within a few days suppuration will be evident. I might remark in this connection, gentlemen, that even at this stage of the development of the bubo, there will be found in every one of these cases more or less purulent infiltration. We will not expatiate upon this point at this juncture.

The question arises, what shall we do with this particular case? All of the standard works upon genito-urinary diseases say: Do not do any cutting operation in these cases of concealed chancroid, as infection of the cut surfaces will invariably occur and a huge chancroid of a size proportionate to the extent of the incision invariably result. The question at issue in such cases is, which is the better practice? To allow these chancroids to go on in their course of destruction beneath the swollen and infiltrated phimosed prepuce, or shall we lay the part open to inspection and thus permit free drainage, cauterization and antiseptic treatment? Suppose the incision does become infected, is not the resulting ulceration open to inspection and treatment? And is not its occurrence more than counter-balanced by the increased facility for treating the hitherto concealed chancroids after the operation? This much I may say, the cure of a case of this kind after incision, is a matter of weeks; without incision, it is a matter of months. We have as a rule, only to fear more or less destruction of the prepuce after thorough exposure of the chancroids beneath it by incision, whereas, in case they are allowed to remain concealed serious destruction of the glans penis may occur. Concealed chancroids are a standing invitation to phagedena and gangrene and serious destruction of penile tissue. Despite the doctrines inculcated by our most eminent authorities upon venereal diseases, I believe that the proper treatment for concealed chancroids is to lay the prepuce open upon the dorsum after the part has been antisepticized by means of the peroxide of hydrogen, followed by a solution of bichloride of mercury 1-1000, injected beneath the prepuce. Any existing sores are then to be cauterized and the parts dressed with iodoform. When upon exposure of the chancroids they are found to be located upon the prepuce and not upon the glans penis, a complete circumcision should be performed, provided we can

thereby remove the chancroids. This, however, should not be done until the parts have been thoroughly deluged with antiseptic solutions and the chancroids thoroughly cauterized. I have operated upon such cases in this manner and had them heal by first intention, and I cannot say that I have ever operated upon a case where I had occasion to regret it. I must say, however, that I have on several occasions been unjustly criticised by some of my professional brethren who are adherents to the dogma of infallibility of authorities and into whose hands cases upon which I had operated subsequently fell. If phagedena does not attack these cases after the operation they do perfectly well, and phagedena is much less likely to attack the parts after than before an operation.

I will proceed in this case to lay the prepuce open as I have directed. I find on slitting it open upon a director several chancroids upon the prepuce itself. These I will cauterize thoroughly with carbolic acid. I will then trim off the ragged prepuce and thus make a complete circumcision. I will now, after stitching the cut edges together, apply powdered iodoform with a small iodoform gauze roller bandage. The wound may possibly not heal by first intention, but if not, the parts will be in much better condition for healing than prior to the operation. It would not surprise me at all to find within a few days on redressing the part that the incision has healed by first intention.

TRANSMISSION OF TUBERCULOSIS BY THE SEMINAL FLUID.

At a meeting of the Society of Anatomy and Physiology of BORDEAUX, SOLLES (*Journal de Médecine de Bordeaux*, 1892, No. 5, p. 52) reported the results of experimental inoculation of two guinea-pigs, the one with the fluid expressed from the testicle of a tuberculous subject, and the other with the spermatic fluid obtained from the seminal vesicle of another tuberculous subject. In the first, the induration at the site of inoculation slowly disappeared, without involvement of adjacent glands, and the animal recovered. In the case of the second guinea-pig, fatal general tuberculosis developed. The evidence, in so far as furnished by a single case, points to the hereditary transmissibility of tuberculosis.

COMMUNICATIONS.

SHALL PHYSICIANS BECOME
SALES-AGENTS FOR PATENT
MEDICINES?*By SOLOMON SOLIS-COHEN, M. D.
PHILADELPHIA.

SECTION 4 of Article I of the By-laws of the Philadelphia County Medical Society reads as follows:

"Any physician who shall procure a patent for any instrument of surgery, or who sells or deals in patent remedies or nostrums, or who shall give a certificate in favor of a patented or proprietary remedy or patented instrument, or who shall enter into an agreement with an apothecary to receive pecuniary compensation or patronage for sending his prescriptions to that apothecary, shall be disqualified from becoming or remaining a member."

Article VIII of the By-laws of the Philadelphia County Medical Society, accepts as an integral portion of those by-laws, the Code of Ethics of the American Medical Association.

A section of that code of ethics treats "Of the Duties of Physicians to Each Other and to the Profession at Large." Article I of that section sets forth "Duties for the Support of Professional Character." Section 3 thereof condemns open or underground advertising as "derogatory to the dignity of the profession." "These," it says, "are the ordinary practices of empirics, and are highly reprehensible in a regular physician." Section 4 continues:

"Equally derogatory to professional character is it for a physician to hold a patent for any surgical instrument or medicine, or to dispense a secret *nostrum*, whether it be the composition or exclusive property of himself or of others. For if such *nostrum* be of real efficacy, any concealment regarding it is inconsistent with beneficence and professional liberality, and if mystery alone give it value and importance, such craft implies either disgraceful ignorance or fraudulent avarice. It is also reprehensible for physicians to give certificates attesting the efficacy of patent or secret medicines, or in any way to promote the use of them."

*Read before the Philadelphia County Medical Society, April 27, 1892.

To the clearness and force of this dictum nothing can be added. Its wisdom and its justice are beyond dispute.

It is unfortunately true that much of our therapeutics is as yet empirical. Nevertheless the best endeavors of the true physician are directed toward establishing a rational basis for that which experience has proved to be beneficial; toward obtaining scientific data by which to make progress to a therapeutics not empirical; and toward eliminating from the traditional heritage of the profession such measures as may have had their origin in superstition or mistaken observation. To use preparations of unknown composition; to use mixtures of innumerable substances, some directly opposed to each other; to use even rational and known combinations of which the ingredients and proportions have not been adjusted to the indications and conditions of the individual case—are certainly not scientific methods or practices likely to advance rational therapeutics.

That much of the flavor of the mystery and witchcraft that at one time appertained to the practice of the healing art should have survived among the vulgar, is only a phenomenon to have been expected in the natural course of social evolution. Hence it is that homœopathy, and mind-cure, and patent medicines, have so powerful and so profitable a hold upon the purses of the community, and this not alone among the ignorant and the unlettered. It is a notorious fact that the clergy—presumably educated and intelligent men—are among the most prominent and persistent givers of testimonials to the virtues of advertised nostrums, and medical men and medical journals have long made the religious press a target for satire and invective, because of the hold that the advertising quack has secured upon its columns.

In an address to the Medical Society of the State of Pennsylvania at its last meeting, in calling attention to the alliance between the secular press and the empirics and *nostrum*-venders, I felt justified in saying that the publishers of magazines and newspapers that allowed themselves to advertise the curative virtues of this or that ready-made preparation or alleged remedial measure, to be applied indiscriminately to all cases—whether of one disease or of many diseases—were accessories to a crime against the unfortunate and the

helpless; not alone because of the money filched from the pockets of those deluded by the false promises held out to them; not alone because of suffering unrelieved and lives deprived of their chance for prolongation; but in many instances because of the disease and suffering and death directly produced by the poisonous compounds or noxious gases administered to any that chose to purchase. If such criticism was justified—and who is here that will deny its truth?—if such criticism was justified when applied to those who make no pretence of special knowledge or of devotion to a noble art—to those whose object is solely and avowedly commercial—what language remains to characterize the action of medical journals that permit the insertion in their columns of advertisements such as these that I pass around? *Journal of the American Medical Association*? What words of condemnation are strong enough for the physician that permits his name to be associated with these devices of the devil?

The frankly unscrupulous patent-medicine vender, the maker of "Safe-cures," or "Temperance Bitters," or "Sure-Specifics," is at least to be commended for what, to paraphrase a remark of Senator Benjamin Harrison's, may be termed his "bold brutality." His allegations of philanthropic motives are not intended to be believed; they deceive no one—they are the recognized *ad captandum* devices of the clever advertiser—and, in the sale of his wares, there is no pretence of examination, or of diagnosis, or of prescription based on diagnosis.

Far more iniquitous and far more dangerous to society is the wily manufacturer that advertises "to the profession only." Whether he ostentatiously holds secret the composition of his nostrum, or whether with pretended frankness he describes it with an appellative that means nothing, or publishes a formula that cannot be carried out, his object is the same; he seeks to make the physician's the hand whereby he may reach pockets shut from the coarser methods of the Warners, the Pinkhams, and the Jaynes; for, after all, it is the minority that can be deluded by the flaring posters of "Wizard Oil," or the lying testimonials of "Tonic Vermifuge." When a sick man applies to a physician, thinking that thereby he will secure the benefit of special knowledge brought to bear upon the con-

ditions of the individual case, entrusting to the conscience of his medical adviser his health and his life, he is entitled to the skill and the thought for which he pays, and that he deems himself to be receiving. He certainly deserves better treatment than to be handed over to the mercies of "antikamnia," or "febricide," or "quick-ine," or "gleditschine," or "Freligh's tablets," or "Listerine," or any other of the unholy crew. If such is to be his fate, let him have the satisfaction of buying the worthless or poisonous stuff direct, without the sham of a professional consultation, and without paying a purchaser's commission to the medical sales-agent.

At the coming meeting of the State Society I purpose offering the following resolutions, for which I ask the support of this Society:

Resolved, That the Medical Society of the State of Pennsylvania hereby expresses its highest disapprobation of the practice of giving certificates or testimonials to secret preparations alleged to be of medicinal virtue, and calls the attention of the affiliated county societies to the fact that such action on the part of members of the said societies is in derogation of the dignity of the profession, and in violation of the letter and the spirit of the Code of Ethics of the American Medical Association and of this Society.

Resolved, That this Society likewise expresses its disapprobation of the practice of inserting advertisements of secret preparations in the columns of medical journals, such action being an insult to the intelligence of the profession, and a degradation of journals indulging therein to the level of the patent medicine almanac. Especially to be condemned is the action of the *Journal of the American Medical Association* in admitting such advertisements.

Resolved, That copies of these resolutions, duly attested by the permanent Secretary, be sent to all county societies in affiliation with this Society, to the American Medical Association, to State medical societies in affiliation therewith, and to the publishers and editors of American medical journals.

On motion of Dr. J. Madison Taylor, the resolutions were adopted as the sense of the Philadelphia County Medical Society, and the delegates to the Medical Society of Pennsylvania were instructed to officially present and support them.

DOES ORGANIC DISEASE OF THE HEART PRECLUDE THE USE OF CHLOROFORM IN PARTURITION? *

BY T. RIDGWAY BARKER, M. D.,
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THE PENNSYLVANIA DISPENSARY.

In entering upon the discussion of a subject of such paramount importance to mother, offspring, and obstetrician, one cannot lay too much stress at the very outset upon the axiom that "A good remedy will fail of its effect if not properly administered." This fact must be kept uppermost in our mind if we would avoid fatal results, not due, however, to the employment of the agent, as some would make it appear, but to the lack of attention and care exercised in its administration. That there is a radical difference between surgical and obstetrical anaesthesia (analgesia), goes without saying. If we consider for a moment the stages of anaesthesia, which differ only in the profoundness of the impression—first, sopor; second, stupor; and, third, stertor—we cannot fail to notice that in analgesia one rarely has occasion to carry the effect beyond the first degree (sopor), while in the surgical variety we are obliged to advance beyond this and keep the patient in the second stage, or that of stupor, thus markedly increasing the gravity of prognosis.

In this connection, let us devote a moment's consideration to the progressive effect of chloroform vapor upon the nerve-centers of the cerebro-spinal system, beginning, as it does, at the inferior extremity of the cord, sacro-lumbar, and gradually extending its paralyzing influence upward until it reaches and expends its force upon the medulla oblongata. These well-established clinical observations having been verified by physiological experiment, we are justified in putting them to practical use. What other agent, may be pertinently asked, can relieve—aye, abolish—pain so quickly and safely, yet leave reflex muscular contractility unimpaired, as chloroform? Ether and ethyl bromide have

found favor with some practitioners, but neither can displace chloroform.

Fordyce Barker states in his writings: "I may say here that I have long regarded chloroform as the best and safest anaesthetic in obstetrics, and that since 1850 I have used no other."

The danger from the employment of chloroform in this department of medicine depends more upon the carelessness with which it is administered than to any toxic effect inherent in it. The four cardinal points to be borne in mind when giving this anaesthetic are: First, plenty of pure atmospheric air; second, liberation of a small amount of the vapor at a time; third, attention to the respiration; and, fourth, frequent observations as to the force and frequency of the cardiac action. That the recorded cases of death have been due in a great measure to saturation of the residual air in the lungs to a fatal degree can scarcely be doubted. A few deep, forced inspiratory efforts will quickly produce such a condition. Withdrawal of the agent under these circumstances cannot prevent the further entrance of the chloroform vapor into the circulation, for it already fills the air-cells. Nor will attempts at artificial respiration prove effectual, since but a small quantity of the residual air can be forced out of the lungs, while that which enters fails to sufficiently dilute the vapor owing to the tardiness of diffusion. Let us not suppose, however, that because we administer to the parturient female small amounts of the drug continuously, therefore no risk is incurred, for experiments directed to solve this important question go to prove that even small doses, when continuously inhaled, tend to produce dangerous, and at times fatal, cardiac exhaustion. Far different is the result when given intermittently, as is the unalterable rule in obstetrics. Should we seek authority for the statement that the dangers from the careful administration of chloroform in labor are too insignificant to warrant its refusal, we have only to turn to the *American System of Obstetrics* to find therein the following: "The danger when chloroform is used only to the extent of mitigating or abolishing pain in childbirth is practically nil." Lusk, quoting from Bert's experiments, states "that chloroform might be intermittently administered for an indefinite period with safety." These remarks do not apply to its use in

* Read before the Philadelphia County Medical Society, April 27, 1892.

the third stage of labor, for as is well known, after delivery of the child it is likely to occasion relaxation of the uterus, thus favoring post-partum hæmorrhage.

Offering the above as a preface to my remarks on the judiciousness of employing chloroform when the parturient female suffers from organic cardiac disease, it now remains for us to consider the effect of parturition upon this enfeebled circulatory organ, thereby securing a scientific basis for our conclusions. In the first stage of labor we find the muscular contractions confined to the uterine muscular layers and directed toward overcoming the circular fibres of the cervix, while in the second or propulsive stage not only does the uterus exert its power to the utmost, but also the abdominal and respiratory muscles are brought into action by the will of the parturient in her efforts to expel the fœtus. The diaphragm is forced down and its movements paralyzed by the female holding her breath.

The other respiratory muscles are likewise unable to act, and hence imperfect oxidization of the blood results. As a consequence, the cardiac movements are accelerated, greater resistance is met with in the pulmonary and aortic circulations. Moreover, a tendency exists to venous congestion, as evinced by the hue of her face and swollen veins.

Owing to the excruciating pain experienced when the head passes through the cervix, the parturient is further tempted to make additional muscular efforts, which only augment the difficulties met with. Under normal conditions this strain is of such brevity that it cannot be considered of any importance, but when complicated by disease of the heart it is of far greater gravity. If the condition be one of fatty degeneration due to a previous peri- or myocarditis, resulting in faulty nutrition and enfeeblement of the heart's action, as evinced by weak impulse, venous stasis, confused and irregular sounds, anæmia alike of brain and other organs, with faintness and oppression on the slightest exertion, this interference with circulation and respiration may readily tax its powers too far, and so cause speedy death from paralysis. Here the conditions which pertain in surgical anæsthesia are absent. The indications present are to allay excessive muscular action and respiratory spasm

which is threatening the over-stimulated heart.

To allow the female to continue such efforts is to permit her to commit suicide; to warn her to desist is useless when in such agony; while delay is likely to be fatal. How can we overcome this condition of nervous excitement? Can we accomplish it by the administration of chloroform? Yes; of the two evils, for we must acknowledge there is an element of risk in giving chloroform, we can only choose the lesser, and so promptly proceed by inhalation to relieve the accessory muscles of parturition of their strain. By the abolishment of pain we lessen the work required of the laboring heart, which, instead of beating at a rate of one hundred and forty or more a minute, may diminish in frequency to ninety or one hundred.

What has been said of fatty heart is equally applicable to conditions of hypertrophy and dilatation.

The equilibrium, if disturbed, is almost certain to result disastrously. That sense of fullness in chest and oppression due to bronchial congestion, if relief is not afforded becomes most distressing. The cyanosis from deficient aëration is greatly exaggerated, while the insufficient blood-supply to the brain causes syncope and may be succeeded by coma if the excessive reflex disturbance be not removed. Nor are the indications for the administration of chloroform materially different in the case of females in labor with valvular disease. Whether it be mitral in the young adult or aortic in the aged primipara the cardiac strain must be relieved if we would save our patient. As is well known, all forms of valvular disease ultimately develop a condition of ischæmia on one side with corresponding low tension, while on the other side is stasis with high tension. While by compensation life may run on for years, yet, when the strain of parturition comes, it will soon be overthrown if precautions are not taken to prevent it.

Of what benefit will be our knowledge of the value of cardiac "physiological rest," as laid down by Fothergill, if we do not apply it under these conditions? We all appreciate the importance of securing "quietude of mind and body" when such pathological states exist. Then why not employ the quickest and safest means to obtain it by the inhalation of chloroform? If the danger is great from "active exer-

cise—climbing mountains, running up stairs, lifting heavy bodies, and all kinds of exercise involving heart strain”—how much greater, aye, how immeasurably so must it be when the parturient female forces, with the anguish of despair, every muscle to its utmost in her desire to deliver her child. From a study of chloroform anæsthesia in obstetric practice we have seen how it should be administered and how it acts. Surely none will deny that in its employment under these circumstances we act otherwise than for the best interest and safety of our patient. That one may not be charged with being a blind adherent to theory, one has only to turn for support and justification to the teachings of the late lamented Fordyce Barker, who states: “It seems to be almost accepted as an axiom, with both profession and public, that the inhalation of chloroform is dangerous to any woman with disease of the heart. For more than thirty years I have been convinced that this opinion is quite erroneous, and I have so taught in my lectures and in former writings.”

He goes on further to say: “I have seen several cases, complicated by dangerous heart lesions, which terminated favorably, as I think, solely from the use of chloroform.”

Snow, likewise, is of this opinion, “In all forms of valvular disease,” he says, “chloroform, when carefully administered, causes less disturbance of the heart and circulation than does severe pain.” To quote from Championnière: “If,” he says, “I recognized an organic affection of the heart, without pulmonary complications, I should rather give the woman chloroform than to let her suffer.” Were further proof necessary as to the propriety of employing chloroform anæsthesia, one might include among this group of clinical observers, Vergeley, who expresses himself thus: “Diseases of the heart are not a contra-indication to the use of anæsthesia.” Macdonald states: “In almost all cases of heart disease with labor chloroform has been given, and apparently with benefit, during delivery. If carefully administered I think it cannot but be useful in all cases.” Since such eminent authorities advocate its employment can we justify ourselves in refusing our patients the benefit and comfort this agent affords? What is the danger from chloroform compared to the state

of exhaustion and collapse into which the parturient female will inevitably fall? If this heart is forced to the verge of paralysis from overwork and excitement, why shall we not use the means at our command to lessen that strain? Let us have a reason for the faith that is in us, and not hesitate to fearlessly employ extreme measures to overcome extreme dangers.

Chloroform by inhalation can and will, if properly administered, save the lives of parturient females, suffering from organic disease, when death seems imminent from over-stimulation of its ganglia through reflex nervous action. Organic heart disease, then, does not preclude the use of chloroform in labor, but rather is a condition calling for its careful administration.

THE TREATMENT OF CYSTITIS BY CORROSIVE SUBLIMATE.

Guyon (*Bulletin Médical*, January, 1892,) reports the good results obtained from the use of corrosive sublimate, in the form of washings or better still by instillation, in the treatment of 26 cases of cystitis. Tubercular cystitis, which is only relieved by a general treatment, seems to receive marked benefit from the use of the bichloride of mercury. The cases of cystitis which are notably benefited by this drug however, are those occurring in progress from this ointment, and what was especially remarkable was the marked diminution of the inflammation of the affected organ has subsided. When the capacity of an inflamed bladder is small, then the instillations are to be preferred, for, under these circumstances, the contact of the remedy with the mucous membrane is prolonged, and the injection allowed of larger doses. The solution employed should be, at the beginning, of the strength of 1 to 5,000, this being gradually increased to as high as 1 in 1,000. The instillation must be made on the posterior portion of the urethra, never injecting more than 20 or 30 drops at the beginning of the treatment. Later on 4 and even 8 grammes may be employed, if, however, pain is produced at the onset, the number of drops must be diminished. Before injecting the medicine the bladder should be emptied. The washings may be employed at the later stages of the affection, when there is absence of pain.

ERRORS OF REFRACTION AND THEIR RELATION TO HEAD- ACHES AND OTHER RE- FLEX NEUROSES.*

By F. R. REYNOLDS, M. D.,

EAU CLAIRE, WIS.

This subject has been so often before the medical profession of late, that I feel I almost owe an apology for again bringing it to their notice. My only reason for so doing, is that I may emphasize its importance and impress the necessity of a thorough examination of the eyes when no other methods of treatment succeed in effecting a cure in obscure nervous troubles. By a thorough examination, I mean one in which the accommodation has been paralyzed by a mydriatic, so that the entire amount of refractive error, both manifest and latent, may be ascertained.

That there is often a wide difference between manifest refractive error, and the entire amount as brought about by the paralysis of the accommodation, I shall show by citing a number of cases from my own practice.

Very often in the young, there is not only no apparant error of refraction, but by a spasm of the accommodation, hypermetropic eyes often show an apparent myopic condition, and myopic eyes show an increased degree of myopia. Patients often come to us with the complaint that their eyes are weak and they think they require a little strengthening eye wash; when judicious questioning often develops the fact that they have been subject to headache, more or less, for a number of years, and the letters sometimes blur after continued reading. Such patients will scoff at the idea of requiring glasses, claiming they can see "as well and as far as anybody."

Although in childhood while the power of accommodation is still good, constant close work is possible to these cases, it grows more and more difficult as the range of accommodation diminishes with advancing age: or this condition may be brought on in children as a result of severe disease or after excessive ocular strain.

The power of accommodation may be maintained for a certain length of time,

then it relaxes, the letters become indistinct, objects become confused, the eyes begin to smart and to burn, and if work is continued pain in the eyes and head result. The pains often assume a neuralgic form, but after their long continuance the headaches sometimes become independent in character and persist after the strain is removed. Treatment in such cases is of no avail until the ciliary irritation is relieved. It is not until then, that the remedies indicated produce their effect. The patient may not show any refractive error upon examination by means of the trial case; but by retinoscopy, or after the accommodation has been paralyzed by a mydriatic, a decided and sometimes very considerable degree of ametropia is discovered.

I have known cases to show no error of refraction at all, or only a slight degree, that by retinoscopy or after preparation by a mydriatic have shown as high as 2.50 to 3.00 D.

In a paper read by Dr. Dana, Prof. of Nervous Diseases in the New York Post Graduate Medical School, "On Chronic Headaches of Functional Origin," we find the following: "At the present time the eye is credited with giving rise to an immense number of head pains.

"Their location depends, not only upon the pathological condition of the eye, but also upon the constitution and occupation of the patient. From my investigations, it seems to me that the most general rule which one can formulate is that headaches of refractive errors are usually frontal or orbital, those from muscular insufficiencies are more often occipital and cervical."

And it is here pertinent to remark that Prof. Dana is not a specialist in Ophthalmology.

Meyers in his work on diseases of the eyes says: "Again, patients never fail to tell us that they do not see so well near at hand, as at a distance, and that their eyes get tired very easily when their work requires close application. This feeling of fatigue in the eyes is accompanied with pains in the peri-orbital region and sometimes with headache. This is a symptom which at once sets us on the track of the diagnosis."

"In writing of Habit Chorea, de Schweinitz wishes to emphasize the fact that if the habit spasm especially affects the mus-

*Read before the Inter County, Med. Society at New Richmond, Wis., March 8, 1892.

* An. of Univ. Med. Sci. 1889, B. 60.

cles of the face, particularly those around the eyes, the following points deserve attention:

1st. The condition of the refraction and the muscle balance should be carefully examined.

2nd. The anomaly of refraction under complete ciliary paralysis, and the full, not partial, correction ordered.

3rd. This correction should be employed in conjunction with proper internal medication and general hygiene and not to the exclusion of these measures."

* "Gould reports a case of chorea in a girl, that, without, amelioration, had been treated for two years in a hospital with large and long-continued doses of arsenic.

This treatment was discontinued upon ordering spectacles, and within three weeks after the correction of her compound hyperopic astigmatism the chorea entirely disappeared, (not returning in six months) and with it likewise her headache, dizziness, violent bursts of temper, etc.

† He also calls attention to the influence of errors of refraction upon developing character and vocation in life. The subtle influence of even slight eye-strain may in the young work deleteriously upon the disposition and the mental life, or slowly turn them from occupations otherwise chosen."

‡ Colburn gives the case of a minister, who, upon account of frequent epileptic seizures and mental disturbance associated, with inability for use of eyes, had, after eight years of suffering; an insufficiency of the external recti muscles treated by exercise with prisms, and an hereditary hypermetropic error of refraction carefully corrected with proper glasses.

From this time the patient gradually improved, until, at the date of the report, he had had no seizures for more than one year, and his mental condition had become so much better, that he was, to use his own language, "able to do a good day's work without any symptoms of his old trouble."

§ Based upon twenty observations, George Martin, in an article entitled "Ophthalmic Migraine and Astigmatism," deduced the fact that bilateral migraine always is the greater on the

same side as the stronger contraction of the ciliary muscles, and that relief is afforded by the use of the correcting lenses.

Six cases of migraine were met with in the practice of Percy Jenkins, five of which showed hypermetropia from one to two dioptries, and one, myopia of 2.25 D.

Correction of the refractive error was followed by absolute cure in every case."

* "Among sundry neuroses Harper reports the details of two cases of obscure but varied mental trouble due to hyperopic and astigmatic errors, that disappeared at once on their correction.

Hewetson cites illustrative cases of insomnia and general symptoms usually called hysteria, such as tenderness of the spine and skin generally, great nervousness, etc., that were distinctly traceable to irritational eye-strain. Gould describes a case of extreme rapidity in the cardiac action (130 beats per minute) that had resisted other therapeutic attempts for several months, (which had come on after prolonged reading at night,) and that was followed by loss of health, flesh, etc.

With a correction of the existing astigmatism, there was a speedy reinstatement of normal conditions."

The following were selected from my case-book as illustrative of some of the conditions mentioned in this paper:

CASE I.—Miss. H. T., Stillwater, Minn. Consulted me Sept. 25, 1885. She came to me, her eyes filled with tears, and so overcome by her feelings that she was scarcely able to speak. She told me she was sure she was going blind, sooner or later, and that she was completely discouraged.

Her symptoms, in her own language, were as follows: "My eyes have always been weak, and I have been subject to sick-headache ever since I can remember. I often have to go to bed and lie the entire afternoon the pain in my eyes and above them is so severe. At times, I get so dizzy as to nearly fall, and then everything gets black in front of me, and I think I am surely going blind; but usually, after a night's rest, the symptoms disappear, and I feel encouraged again, only to go through with the same pain and suffering, upon the slightest use of the eyes."

She said she had taken medicines for her headache ever since she could remember,

* An. of Univ. Med. Sci., 1890, B. 140.

† An. of Univ. Med. Sci., 1889, B. 82.

‡ An. of Univ. Med. Sci., 1889, B. 83.

§ An. of Univ. Med. Sci., 1890, B. 140.

* An. of Univ. Med. Sci., 1889, B. 83.

but nothing ever produced any lasting benefit. I told her to take courage as I thought I could bring her out alright.

After a thorough paralysis of the accommodation, I found her refractive error to be as follows: viz—

R. E. +3.00 D.Sph. \ominus +1.25 D. Cyl. Ax. 90°

L. E. +3.00 D. S. \ominus +1.25 D. Cyl. Ax. 60°

I gave her full correction and advised her to wear her glasses constantly.

Under date of Feb. 23, 1892, she writes as follows: "As soon as I got my glasses from you my trouble began to subside, and in a short time I was entirely free from my headache and other unpleasant symptoms.

"I am very grateful to you, as I can now do any kind of work with my eyes, day or night, and am not troubled in the least.

"Could not possibly get along without my glasses, for at times, I have tried to do so, but cannot read more than a few minutes before my eyes commence to pain."

CASE II.—Miss M. Z., *et.* 17, St. Paul, Minn. Called Sept. 17, '89. Strabismus, L. E. 21-2 lines. Subjective symptoms as follows:—Has pain in the head and eyes when used excessively. Pain commences in the eye-balls and shoots through the head. Has frequent attacks of nausea and dizziness.

Vision R. E. $\frac{1}{10}$ L. E. $\frac{1}{10}$ with +1.00 D. S \ominus +

.25 D. Cyl. Ax. 180° for R. E. V— $\frac{1}{10}$ With +2.00 D. S. \ominus +

.25 D. Cyl. Ax. 180° for L. E. V— $\frac{1}{10}$ Under mydriatic, refractive error discovered was as follows:—

+2.00 D. S. \ominus +.25 D. Cyl. Ax. 180° both eyes.

Corrected strabismus and prescribed above combination with the result of entirely curing trouble.

CASE III.—Miss M. C. Menomonie, Wis. *Aet.* 18 years. Consulted me August 27th, 1885. Subjective symptoms:—Holds her book very close to eyes. Constant headache while studying. Complaints of nervousness and insomnia. Vision, $\frac{1}{10}$ both eyes.

Before using mydriatic I found the following combination of hypermetropia and myopic astigmatism. R. E. +2.50 D. S. \ominus -3.00 D. Cyl. Ax. 10° L. E. +2.50 D. S. \ominus +2.75 D. Cyl. Ax. 170°.

After using mydriatic, R. E. = +5.00 D. S. \ominus -3.50 D. Cyl. Ax. 10° L. E. = +5.00 S. \ominus 3.50 Cyl. Ax. 170°.

These glasses entirely relieved patient of all headache, nervousness, and insomnia.

CASE IV. Mrs. A. J. A., Rock Elm, Wis., *et.* 35 years, consulted me Jan. 20, 1890. Subjective symptoms given at the time read as follows:—Eyes often get dim while reading or sewing. Great pain in periorbital and frontal regions after continued use of eyes. Has frequent attacks of "blind headache." Vision: R. E. $\frac{1}{10}$ +, L. E. $\frac{1}{10}$

Manifest hypermetropic astigmatism is as follows:

R. E. +.50 D. Cyl. Ax. 90°: L. E. +.75 D. Cyl. Ax. 90°.

With the above correction V. was $\frac{1}{10}$

After use of mydriatic a compound hypermetropic astigmatism was revealed.

R. E. +2.50 D. S. \ominus +.50 D. Cyl. Ax. 90°.

L. E. +2.25 D. S. \ominus +.75 D. Cyl. Ax. 90°.

Full correction was given with immediate relief, and after three weeks all pain and headache had disappeared.

CASE V. Mrs. P. A. L., Spokane Falls, Wash., *et.* 50 years, consulted me August 26th, 1889. Subjective symptoms given as follows: Eyes been weak for 25 or 30 years. Has frequent attacks of nervous headache. Worn glasses 20 years, but never was fitted by an oculist, and never wore glasses for distant vision. V.— $\frac{1}{10}$

Without use of mydriatic, the following refractive error was discovered:

O. D. +1.75 S. \ominus +.75 C. Ax. 70°.

O. S. +1.75 S. \ominus \times .50 Ax. 160°.

With this correction V. was $\frac{1}{10}$

I prescribed biocal glasses with above combination for distant vision; and the addition of +2.75 S. for-reading, with very happy result; as she writes me under date of Sept. 20th, 1891., that "she can use her eyes all day without pain or discomfort and she is entirely cured of her nervous headache."

CASE VI. F. C., Crookston, Minn. Aged 8 years. Came to me Dec. 15th., 1888. Has had chorea two years, since first commencing to attend school. She is weak and anæmic, and complains of always being tired. First symptoms manifested were twitchings of the eyelids and face, which were soon succeeded by characteristic jerking of the legs and arms, and at times inability to maintain her equilibrium in walking.

Added to these symptoms were severe

attacks of headache; periorbital and frontal. She was removed from school and treated with tonic remedies: iron, strychnia, arsenic, and finally by electricity with beneficial results, and apparent cure; but upon returning to her school work, the trouble would again manifest itself; and so continued until she came under my care. She was brought to me on account of "Blepharitis Marginalis" which had also existed for two or three years.

After obtaining a history of the case, an error of refraction immediately suggested itself.

Upon examination no manifest error was discovered, but after obtaining complete ciliary paralysis she showed;

R. E. +2.75 D. S. \ominus +.50 D. Cyl. Ax. 70°.

L. E. +2.75 D. S. \ominus +.50 D. Cyl. Ax. 160°.

I gave her full correction to be worn constantly; also gave ointment for application to edges of eyelids.

She began to improve almost immediately the nervous phenomena manifesting themselves less and less frequently until at the end of three months they had ceased altogether and have not since returned.

*Goode in an article on "Headaches due to Disorders of Vision" believes that the increase in the number of spectacles worn is not to be regarded as an evidence of modern degeneration of the eyes and threatened further alterations unless we call a halt in some of our ways but rather that a long-felt necessity has been met.

Although I fully agree with Goode in the above, in addition I feel called upon to say, that in my opinion, the present system of education, has a great deal to do with developing these various nervous and mental disorders. The too rapid advancement in the education of the young; and the habit of placing so much of the work upon the black-board, from which the pupil is required to recite and to copy: the blackboard work being to my mind especially pernicious.

URTICARIA.

For the atrocious itching of this disease, Quinquaud prescribes the following lotion:

R. Acid borio.....grams 30
Chloral hydrat....." 5
Aq. dest....." 160 M.

*Annual of Univ. Med. Sciences, 1889, B. 33.

TREATMENT OF HEMORRHOIDS BY CARBOLIC ACID INJECTIONS.*

By J. W. HALLUM, M. D.

CARROLLTON, GA.

The treatment of hemorrhoids by carbolio acid injections, is a treatment that I hesitate to present and advocate before this association, not because of any of its defects, but on account of its opponents.

To Colles of Dublin has been accorded the honor of first treating piles hypodermically, in 1874. Dr. S. H. Sturgeon, of this country, claims that he reported cures by the carbolio acid injection in the *Medical Brief* for 1874. There was but little attention given the subject before Dr. W. P. Agnew, of San Francisco, reported his cures by the treatment in *The Toledo Medical and Surgical Journal* in 1877. In 1880 Dr. Blackwood, of Philadelphia, reports his cures by it in the *New York Medical Record*. Since that time there have been volumes written on this subject.

Therefore I do not expect to introduce anything entirely new, but I do hope that I may be able to interest some of you who have not been making satisfactory cures of this very common disease.

Why you have not I shall not attempt to explain, but describe my mode of procedure in a country practice, where the office is unhandy, and an operating table or chair unknown.

It is not necessary to be a specialist in order to be successful in the treatment of piles by this method. By it quacks have succeeded admirably and made inroads on our practice?

The cure of this disease is comparatively unknown by the average physician. Are we not too often neglecting the more common diseases for the more rare? Therefore, I have offered no apology for claiming your time and attention for a few minutes.

It is not the object of this paper to give definitions, symptoms and varieties of hemorrhoids. I know of no reason why I should discuss the pathological anatomy of pile tumors; for they are all alike amenable to this treatment, whether recent or of long standing, venous or arterial origin, blind or bleeding, external or internal.

*Read before the Georgia State Medical Association April 22d, 1892.

* Hemorrhoids are sometimes complicated with abscess, ulcer, fissure, fistula and prolapsed rectum.

The works of Kelsey, Allingham, Smith and others give all the discriminating points of diagnosis, and I would respectfully refer you to them for such information. It is absolutely necessary to make no mistake in diagnosis when we go to apply the carbolic acid treatment. Because I am satisfied it would be unsafe to inject a prolapsed rectum or other healthy tissue with carbolic acid.

Piles are uncommon in either sex before puberty, and I have never yet seen one in children. However, Mr. Bryant in his *Surgery* on page 533 speaks of a treatment and says it is alike beneficial to child and adult.

I know of no cause of hemorrhoids that would contra-indicate the use of carbolic acid treatment. Yet I would not urge this mode in all cases without regard to the patient's previous history. We are often applied to for treatment for piles when there is really no pile—nothing more than an irritated rectum, caused by straining, diarrhoea, a night's debauch or the presence of some foreign substance. Such cases will readily yield, generally, to hot water enemata administered two or three times daily.

There is another class of cases that I always advise to "wait for a more convenient season" to receive treatment. These are cases of pregnancy. The household syringe will render these also bearable until her term is passed, and then if her piles continue we should advise her to have them treated.

But in most cases that apply for relief it is unnecessary to delay, but proceed at once to make cure of the pile tumor. We do this by mixing together pure carbolic acid one part, and pure glycerine two parts, and enough morphine and tannic acid that ten drops of mixture will contain one quarter of a grain each. Let this be thoroughly dissolved before using it.

I will not describe all the positions in which a patient may be placed for this operation. It is so simple that it can be done in any position that will command a good view of the tumor.

The position that I have found to be probably the best is the one in which a toad assumes when in a sitting posture. In this position the patient will almost in-

variably pass out the tumors by an effort at straining down. However, if he should fail then by gently manipulating with the fingers the contraction of the anal sphincters will be overcome and allow the tumor to readily pass out. When operating in the office I use a table about 18 or 20 inches wide, 30 inches high, with a stool at one end. The patient steps on the stool with the knees and lies down on the table, the face downward, this is a splendid position for this operation. For obvious reasons we select the tumor highest up the rectum for first injection. We then insert the needle at right angle to the base of the tumor near its base, and let the deposits be made at different places by moving the needle as the process of injection takes place. Allow the needle to remain in position till the blood of the tumor is coagulated which will be accomplished in about half a minute. Then the tumor is reduced when possible, well greased, and the operation is complete for that time. There is more or less burning for a few minutes consequent upon the injection, after which in the course of five or six days the tumor begins to throb and ache from the swelling and also the death of the pile itself. This pain will continue generally from one to not over fifteen hours. The latter is in case of a large external irreducible tumor. In about three or four days the sloughing is complete leaving a granulating surface which heals rapidly. After the healing process is complete the next tumor may be treated in a similar way to the first and so on till all have been destroyed.

We prefer to inject the tumor while it is engorged, in which case the pain is not increased but actually diminished. I have never yet needed a speculum or any other instrument except the hypodermic syringe to do this operation successfully.

We will suggest that not over two or three small tumors be injected at a time, and not over one when it is very large, because of the swelling consequent from the operation. Patients seldom suffer more than they do at any other time from a fit or paroxysm of the piles.

We would advise our patients not to indulge in any physical exercise that requires much effort, but ordinarily they are able to be up and do light work all the while. Nothing more than a gentle laxative should ever be used for the bowels.

For the last ten years this plan of treat-

ment has never produced any alarming symptoms—no secondary hæmorrhage and sloughing except the pile itself. By it I have yet to report my first failure. By this mode Drs. E. J. Dennis of Kansas City, Fred R. Boyd of St. Joseph, Mo., Q. A. Shufford of Tyler, Texas, W. L. Rodman of the University of Ky., have cured their hundreds. While W. P. Agnew of San Francisco, Ivies and Davis of Chicago, Kelley of Cincinnati, Monroe of Louisville, E. F. Hoyt of New York, have cured their thousands.

BORATE OF SODIUM IN THE TREATMENT OF EPILEPSY.

According to Mairat (*Le Progrès Médical*, February 6, 1892) the use of borate of sodium demands on the part of the therapist, certain precautions. The physiological action of borax is so pronounced, that in certain cases it becomes necessary to suspend it, notwithstanding the good results to be obtained from its use. The remedy exercises its action upon digestion, nutrition, and the skin. On the digestive tract it produces such phenomena as nausea, salivation, a considerable loss of appetite, a dislike for food, and sometimes vomiting and diarrhœa. Upon nutrition it sometimes causes a slight diminution of the bodily weight; but in some cases the emaciation is quite marked, and may be accompanied with swelling of the face, œdema of the extremities, and diarrhœa, giving rise to the production of a true alkaline cachexia. Between these two extremes, the whole range of the disorders of nutrition may be observed. Under the skin, borax produces various eruptions, notably the papular, the eczematous, the scarlatinous, the rubeclic and the furuncular. In administering the drug small doses must be employed at first, that is from 0.50 grammes to 1 gramme, which may be increased gradually, according to the tolerance of the digestive tract. When 8 grammes are insufficient to completely arrest the attacks, it may be concluded that larger quantities are of no advantage. In a general way, with the exception of certain cases, the maximum dose of borax, from which good results may be expected, may be set down as 10 grammes during the 24 hours. When the beneficial limit of the action of the drug has been reached, the doses employed should be diminished.

SOCIETY REPORTS.

CLINICAL SOCIETY OF LOUISVILLE.

Stated Meeting, April 5th, 1892.

P. Guntermann, M. D., President, in the Chair.

RECURRENT PERITONITIS.

DR. W. H. WATHEN:—Referring to the case of recurrent peritonitis reported by Dr. L. S. McMurtry at a previous meeting, it has been my experience that frequently in these cases, there are severe pains in one or both legs; and, I have often had cases where the nutrition of both limbs was much impaired, with cold clammy perspiration, where but one side of the adnexa was involved. But, generally, these disturbances occur in the leg on the side where the tube or ovary is diseased, and they are various, probably sometimes with symptoms of histroneurosis, which will explain the drawing up of the leg in the case reported. These troubles often occur where there is nothing more than simple adhesions which are easily separated, as in the case described, with no pus or hard exudate. There is no way of curing these cases except by surgical interference, and the results are very gratifying. In the case reported the operation was not entirely complete, because nothing was done to prevent the uterus returning to its retro-placed position. It is the safer plan to get permanent results, to fasten the uterus in front by some of the methods devised for that purpose. Formerly to accomplish this, I have used a silver wire, which I do not intend to use again; I will substitute kangaroo tendon and fasten the round ligament and broad ligament to the parietal peritoneum on each side of the abdominal incision. This is the safest and quickest method, and, there is no trouble resulting from it. You might probably do a more artistic operation by suturing the broad ligament and round ligament to the anterior surface of the uterus, thereby shortening these supporters so as to hold the uterus in its proper position. It is bad surgery to attempt to separate the adhesions and replace a retroposed uterus without doing an abdominal section. It does no good and it may do much harm, or cause the death of the patient. There

may be small cavities of pus in the pelvis that no laparotomist is able to diagnosticate until the abdomen is opened, which forcible efforts at replacement might rupture and kill the woman. Adhesions cannot be separated by this method, and a laparotomy will finally have to be performed. I have dilated the womb frequently, and my name is very widely known in this connection, because of an instrument I devised some years ago for this purpose, and which is now manufactured and used in this country and Europe. I have never caused peritonitis by dilatation, but have learned that peritonitis often follows dilatation in the practice of some physicians, even when dilatation is not carried to any considerable extent. I have under treatment a patient with a pus cavity emptying into the rectum; caused by dilatation of the cervix by one of our prominent physicians. I do not think that dilatation of the womb, either extensive or moderate is justified if there are any adhesions.

PELVIC REFLEX TROUBLES.

I will report a case I operated upon about four or five weeks ago, with unusual reflex troubles. Her physician had been giving her three-quarters of a grain of morphia and one-fiftieth grain of atropia three or four times a day hypodermatically. She would get nervous and her pulse would increase in frequency and gradually run up from 80 to 140 per minute; her face would get as red as the blush of scarlet fever; around her neck the skin would be perfectly white; on her arms and body there would be spots two or three inches in diameter, the color of the face, and separating them the skin would be absolutely bleached. In other words, on parts of the surface of the body, there was paralysis of the capillaries, with capillary contraction in the intervening spaces. This would last from two to five hours, coming on sometimes twice daily. I removed an embedded broad ligament cyst, and separated extensive tough adhesions. There was considerable bleeding and a drainage tube was used for two days. She had no outward symptoms from the operation, her pulse and temperature remaining normal. After the operation there was no recurrence of these blushes, until two weeks ago when a friend slipped and fell, striking with her arms upon the abdomen of the

patient. The shock caused severe pain and the morphia, which had been reduced to about one-eighth of a grain per day, has since been increased to from one-quarter to one-half grain daily; her reflex disturbances have returned, but her pulse has not gone above 115 per minute. It may be necessary to do another laparotomy and remove the ovaries and tubes, which were separated from adhesions and not removed, because not badly diseased.

SYPHILIS.

Dr. J. W. Irwin: I bring before you to-night a patient that does not look at all sick, as you will observe. This gentleman fifteen years ago had a small sore on his penis, which was diagnosticated by the physician who attended him at the time, as a soft chancre, which healed up rapidly. He first came under my observation on the 8th day of August, 1890. He was then suffering from pharyngitis, with induration of the soft palate. There were no evidences of constitutional disturbance, no enlarged glands and no eruption of the skin. The throat was not ulcerated, but from its appearance and the indurated condition of the soft palate, I gave the opinion that the trouble was syphilitic, which opinion was not concurred in by the patient. He remained under my treatment until about the 19th of November, 1890, when the throat trouble had yielded to specific medication, and, then, passed from under my observation until early in the spring of 1891. During the interim from the time I saw him, until he returned, he had a series of experiences, which he can tell for himself. Soon after his return I was called to see him and found him suffering from partial hemiplegia, and severe hemicrania. I made a further examination and found that he had nodes on the clavicle and sternum, and there were evidences of similar deposits within the skull; vision was imperfect; a supra-trochlear gland had suppurated. He had gained in flesh and in strength under the treatment I had given him, still, he was not satisfied and sought advice elsewhere. His sight grew worse, and as it did not improve under the treatment he received here, he went to Chicago and there consulted an ophthalmologist who told him that he would never again regain his sight; he was now entirely blind and had to be led. He then went to

Milwaukee and sought the advice of a prominent specialist, who told him that he thought he had about one chance in a thousand of regaining his sight, but, he would not undertake the case unless he could remain with him a year. Very much discouraged and blind he then returned to Chicago and put himself under the care of another physician who concurred in the diagnosis that I had made, and prescribed similar remedies. He came under my care again on the 29th of December, 1891. I found him taking 125 drops of a saturated solution of iodide of potassium three times a day, and his sight had improved enough to enable him to find his way without assistance. I advised that the dose be increased to 150 drops and the improvement continued much more rapidly. As the dose was well borne, soon after I advised that it be increased to 180 drops. Meantime he had gained in weight under these enormous doses from 180 pounds when he commenced the treatment to 267 pounds. One eye is now so far improved that he can see to read, and he can see his hand when passed before the blind eye.

The peculiarity of this case was in the difficulty of diagnosis at first. The induration of the soft palate which would not yield to treatment, led me to believe it was a case of syphilis, notwithstanding the fact that there was nothing in the history indicating that he had contracted the disease. Then, when the supra-trochlear gland became inflamed, I was more than ever convinced that it was syphilis. Finally the appearance of nodes and trouble with his eyes, pointed unmistakably toward syphilis.

DR. W. O. ROBERTS:—What effect did the iodide of potassium have upon the kidneys? Did it increase the flow of urine?

DR. J. W. IRWIN:—Did not notice any change. He is taking now 180 drops three times a day. The stomach seems to stand the dose very well.

DR. W. O. ROBERTS:—This shows that large doses of iodide of potassium can be given in these cases. There are several members present who are well acquainted with a patient, but not with the treatment, that I will mention in connection with the case reported. It was a young man who had syphilis, and had every evidence of involvement of the brain. He was treated by Dr. Bodine and myself, and we gradually increased the dose of iodide of potassium as done in the case related by Dr. Irwin,

until the patient took one half ounce (240 grains) three times a day. We noticed after giving these large doses it produced most copious diuresis, the patient passing enormous quantities of urine. His symptoms yielded to the treatment, then the dose was gradually diminished. I do not remember for what length of time the enormous doses were continued, but for a long time. It has now been fifteen or sixteen years, and there has been no evidence of syphilis since then.

DR. T. SATTERWHITE: I have often spoken of the case referred to by Dr. Roberts as the criterion for large doses of iodide of potassium. Dr. Pusey and myself had a case several months ago, in which there was cloudiness of the cornea, and total loss of sight of one eye. It never yielded to any treatment except enormous doses of iodide of potassium—he took about 200 grains a day and has improved ever since. His restoration to sight is progressing, he is now able to tell the number of fingers you hold up. I believe in large doses of iodide of potassium in syphilitic diseases.

DR. J. A. OUCHTERLONY: I was very much interested in the case, especially because of the obscurity of the diagnosis. We all know especially in cases of syphilis, where there are early symptoms, we may expect various secondary troubles later on. While toleration of large doses of iodide of potassium may be evidence that it is a syphilitic trouble, still, I do not think the opposite will hold good. One does meet occasionally with syphilitic patients who cannot tolerate iodide of potassium; these are exceedingly troublesome cases. I have one of that kind under my care at the present time. In it there is a history of syphilis, with very marked early secondary symptoms, and three years later very extensive glandular enlargements, sufficiently characteristic of Hodgkin's disease to make it a little doubtful whether the patient did not have that. The blood was examined, however, and found to be perfectly normal with the exception of a slight diminution of hæmoglobine. In this case which was undoubtedly syphilitic, doses of sixteen grains of iodide of potassium three times a day gave rise to such unpleasant effects, that it was necessary to diminish the dose. I believe in this case a sojourn at Hot Springs would do good. Possibly we could get beneficial results by carrying out a

"Hot Springs" treatment as well as practicable at home; for instance, large doses of silurian water, and making him take a Turkish bath three or four times a week. Under such circumstances, I think we could make persons who are intolerant of full doses of iodide of potassium take large doses, when, ordinarily they would not be able to do so.

DR. W. O. ROBERTS: Have you ever used digitalis in connection with the treatment of syphilitic cases?

DR. J. A. OUCHTERLONY: Never, unless there were some evidences of cardiac disturbance with it.

DR. A. M. VANCE: I am surprised that Dr. Irwin did not say anything about giving his patient mercury. I do not believe that the tolerance of large doses of iodide of potassium is proof of syphilitic condition. I have seen a number of cases like the one Dr. Irwin described, that have responded after long treatment with iodide much better when mercury was added.

DR. W. C. DUGAN: I have read of a number of cases of syphilitic nature where calomel was used with very gratifying results.

DR. W. CHEATHAM: I understand that mercury can be given by the skin with beneficial results, in cases of syphilis, where patients are unable to take it by the stomach.

DR. J. W. IRWIN: I hardly thought it necessary to go into details concerning the treatment of this case, but remarks would indicate that something on this subject may be said. When this gentleman came under my observation with pharyngitis, I could get no history of syphilis, and when I approached the subject, he denied having had anything of the kind, even the sore. I informed him that I thought he had syphilis, and there was no doubt in my mind that the condition of his throat was syphilitic. The throat trouble would yield to no treatment until I commenced the use of mercury. I gave him mercury by the mouth with very little effect. I then used the method of Lewin and gave injections of one-sixth grain corrosive sublimate hypodermatically, which caused the induration to melt away like snow. I continued this treatment every second day until he had received sixteen hypodermatic injections of one-sixth grain corrosive sublimate. I might say that the corrosive sublimate produced a very decided effect

upon him; it caused vertigo to the extent that he would have to lie down for about half an hour after each injection. Then his skin would become a healthy pink color and normal feelings would return to him. Now, one word in regard to the use of iodide of potassium: I have never treated a case of constitutional syphilis depending upon iodide of potassium alone with the hope that the patient would remain permanently well. There is but one thing, in my opinion, that will cure syphilis, permanently, and that is mercury. Under the use of mercury combined with iodide of potash, or, given alone, I think we may expect the most beneficial results.

DIVERTICULUM OF ŒSOPHAGUS.

DR. J. A. OUCHTERLONY:—At a meeting of the Society some time ago, a case of intestinal diverticulum was presented, which interested me, and, in looking over some of my foreign journals, in connection with this subject, I came across a case that I shall be glad to read. It is a case of diverticulum Œsophagus:

"Mattie B., aged forty-one years: She was admitted to the Seraphim Hospital, Stockholm, on the 24th day of July, 1890. Father died at the age of about fifty years of inflammation of the lungs, her mother died about the same age of consumption. Three brothers and sisters still living, of these two are in good health, one suffering from rheumatism. Four have died during infancy. One sister died at nineteen years of age in parturition. The patient has been married twice, her first husband died four years ago of consumption after suffering many years, and, in this way, causing her a great deal of care and trouble. She has had three children of which the first is still living and in good health, two died about three years of age. During childhood the patient had whooping cough, measles, diphtheria, and at the age of twenty she had a severe attack of typhoid fever, and somewhat later an attack of muscular and articular rheumatism. At times she had been suffering from a cough, but has never had any more serious chest trouble. No disturbances of the digestive organs have been observed. Menstruation has been regular but somewhat abundant. Four years ago she was admitted to the hospital on account of internal hæmorrhage. Her last pregnancy occurred thirteen years ago. The hygienic surroundings under

which she lived were right good, save that during the last winter she occupied a somewhat damp dwelling. Since about six years ago she suffered from time to time with palpitation of the heart, which occurred in paroxysms without any previous exertion or well developed cause. In May, 1890, she began to cough, expectoration was abundant and rather thin, without any mixture of blood; simultaneously she began to have a cardiac uneasiness, and there was also burning sensation in the left scapular region. By midsummer, on account of further severe cough and debility, she was compelled to take to her bed, which she has never left since then. She now began to suffer from a sense of oppression in the throat as if about to suffocate, by a spasmodic contraction of the muscles of the neck. She suffered from constant dryness of the mouth and throat, but there was no difficulty in deglutition, and no swelling of the neck was observed while at her home. Her strength diminished and she seems to have become considerably emaciated. Cough continued the whole of this time, which was rather harsh and barking, without any real hoarseness, nor was there any considerable dyspnoea. At the time of admission to the hospital, the patient complained of great fatigue, and difficulty in expectoration, with sense of suffocation and constriction in the neck. Cough very severe, occurring in longer or shorter paroxysms, during which respiration was quite difficult. There was constant sensation of dryness of the mouth and throat, and, besides this she complained of pain in the right arm, and also, pain here and there in the muscles of chest. The patient meantime in bed showed a preference for position on the right side, or on the back; nutrition was bad, countenance pale, sleep disturbed by cough, appetite poor, bowels sluggish, no tremor, pulse eighty to the minute, regular and full, urine normal, temperature afebrile. Her voice was not markedly hoarse, no difficulty in deglutition, expectoration abundant, amounting to about four cuspidors per twenty-four hours." (These cuspidors, are little cups, kept for the convenience of the patient in bed.) "It consisted of a colorless, watery, frothy fluid, which contained a considerable quantity of mucous, but no yellow elastic fibres or tubercular bacilla. In the lower part of the neck appeared a swelling of half the thyroid gland,

the right lobe being larger than left. In the right supraclavicular fossa, there are some large infiltrated glands; in the left supra-clavicular fossa, there are a number of smaller similar glands, one of them somewhat tender under pressure. Upon laryngoscopic examination it was found that the right vocal cord was immobile during intonation, abduction movement during inspiration absent; the left vocal cord was perfectly mobile. Over both lungs were hard moist râles and ronchi, no dullness anywhere. Nothing abnormal noticed in regard to the heart, or of the abdominal organs. On the 9th of August, the difficulty in respiration had recently increased. When a laryngoscopic examination was about to be made to-day, the patient was seized with alarming dyspnoea that tracheotomy seemed imperative, and on which account she was transferred to the surgical ward, where this operation was immediately performed. No marked improvement in regard to the dyspnoea was effected by the operation. Twenty-third of August, to-day she was returned to the medical section. Twenty-ninth of August, the canula was removed and respiration performed quite well without it. Thirty-first of August—during the past night the patient was suddenly seized with a severe attack of dyspnoea, blood poured abundantly from her mouth; she endeavored, herself, to open the wound in the trachea; when the physician arrived the canula was inserted, but she died almost immediately.

"The autopsy demonstrated as follows: It took place on the first of September, 1890—After opening the pharynx and cesophagus, the mucous membrane was found to be the seat of a tumor which rose to the height of between three and five millimetres, and extended from a level with the larynx down about seven centimetres; it surrounded the whole pharynx in an annular manner, becoming narrow upwards and toward the lower end, leaving the posterior wall and downwards over portion of the anterior wall, free. The surface of this neoplasm is of peculiar formation, consisting of small nodules, these nodules are of greenish white color, and very firm to the touch. On a level with the lower portion of the neoplasm was found on the right lateral aspect of the cesophagus, an opening, which was about the size of the little finger, with rather

smooth, grayish red margins, which orifice opened into an elongated, perfectly incapsulated excavation, filled with dark, dirty, reddish colored fluid contents. This measured in length about seven centimetres, and in width between four and five centimetres. Its walls throughout its whole extent covered with numerous closely adjoining small nodules, which are most variable in appearance, roundish, elongated, periform, club-shaped, etc. Some of them quite slender, others project into the excavation having the form of polypi, hanging by one or more quite slender stalks. These excrescences are of light, grayish red color, and quite firm. The walls including these excrescences have a thickness varying from three to nine millimetres where this sack-like formation projects between the œsophagus and trachea, and to the right of them. It is situated behind the sheath of the vessels and reaches upward to the middle portion of the thyroid gland, both lobes of which are somewhat hypertrophied. In the upper anterior portion is a rupture about eight millimetres in diameter through which it communicates with the trachea. In the lower part it is adherent to the apex of the right lung, over a surface, I suppose, about the size of a five cent piece. Upon incision into the lung this formation is well defined and distinct from the adjoining parenchyma which in the immediate vicinity appears somewhat firm and indurated. As regards the changes in other organs, nothing need be mentioned, save that the trachea and bronchia were filled with a dirty, reddish fluid like that in the cavity just described, and in both lungs was found numerous small recent hæmorrhagic foci, without any indication of the inflammatory irritation apparent in the surrounding area. Microscopical examination shows that both the tumor in the pharynx and the excrescences in the above described sacculated formation, had the structure of chancreoid. It is very certain that the excavation communicating with the œsophagus and trachea is to be regarded as a pre-existing diverticulum of the œsophagus, which had become the seat of chancreoid formation.

"According to Zenker and Zeimssen the present case should be designated as a pulsion diverticulum, which is of considerable interest, because of the secondary changes which have arisen by neoplastic formation in the mucous membrane lining it, and

also on account of its unusual situation in the anterior portion of the right lateral wall of the œsophagus. Usually pulsion diverticulum are situated in the posterior wall between the pharynx and the œsophagus. The very considerable dyspnoea which had more and more developed during the patient's stay in the hospital, and which led to the performance of tracheotomy, was not satisfactorily explained by the paralysis of the right vocal cord, and, as no material improvement was obtained by means of the operation, it was quite apparent that some other respiratory difficulty must have existed. The case is one in which we have to look to the pressure upon the trachea by the enlarged thyroid gland, but this was very moderate. The pathological processes in the œsophagus which were present did not give any well marked symptoms during life. The patient never complained of difficulty in swallowing, and there never was any evacuation of the diverticulum contents by the mouth, the œsophagus was not sounded, as there was no inducement to adopt this procedure, and, possibly, such a manipulation might have hastened the final catastrophe—the rupture of the diverticulum into the trachea."

I have never seen a case at all like this; have never seen a case of diverticulum of the œsophagus, but, upon general pathological grounds, I am not surprised that when such a formation takes place, it should become later on the seat of a malignant growth, a tendency to the development of malignant formations in a number of analogous conditions, is quite common. I remember that a number of years ago, I saw a patient who had an incarcerated testicle in the inguinal canal; the testicle had never descended, and, upon working up the subject I found that a German surgeon in Breslau had collected a large number of such cases, and found a large proportion of them had terminated in malignant growth. Under certain circumstances morbid conditions involving chronic irritation, are likely to develop malignant disease. A very good illustration of this, is the tendency to development of malignant diseases of the liver in connection with the protracted irritation from gall stones.

PNEUMONIA.

I have to report two cases of pneumonia in which the most remarkable feature was

the mode of death: I saw the first one in consultation, probably in 1874, it was a case of right-sided pneumonia, the patient getting along remarkably well until the fourth day: He was propped up in bed, and was in the act of eating some oyster soup, when all of a sudden he tumbled over, dead.

The second case was a female patient, who, several years ago, had presented symptoms of tuberculosis, which had become latent. She was seized with symptoms of croupous pneumonia and by the eighth day the temperature had gone down to 99. At one time evidence of commencing resolution had been observed in the way of returning moist râles. These disappeared, very well marked bronchial breathing with marked dullness returned. The patient seemed to be in a fair way of recovery, the only unpleasant feature was, that while fever had gone down, there was no indication of incipient or even approaching resolution.

On the eighth day she was sitting up slightly, and wanted to drink some lemonade, when all of a sudden she fell back, dead. I think both of these were cases of heart clots. It is not likely that there was sudden cardiac paralysis, because there was no evidence in either case of great cardiac asthenia; the appearance was good in both the man and in the woman, there was not great rapidity of the pulse, in fact, there was nothing to indicate danger in that direction, other than that which is always present in every case of croupous pneumonia. It is a rare termination of this disease, and I think, it is a danger that we ought always to have before our eyes in the treatment of such cases. The occurrence of heart clots is due, first, to the well known excessive hyperinosis that is always present in this disease; secondly, to the over-action of the heart, which naturally leads to cardiac fatigue, if nothing more.

ELIXIR OF COCAINE.

Prof. Huchard, of Paris (*Le Bulletin médicale*, No. 1, 1892), employs, in the treatment of painful dyspepsia, gastralgia and vomiting the following elixir of cocaine:

R	Muriate of cocaine.....	grs. xv.
	Hydrochloric acid.....	f ʒ ij.
	Elixir de gomme.....	f ʒ ij.
	Distilled water.....	f ʒ ij.

A small wineglassful after each meal.

SELECTED FORMULÆ.

ASAFCETIDA IN HABITUAL ABORTION.

Dr. Negri, of Venice, Italy, besides his cases formerly reported where he successfully used asafcetida in habitual abortion (*Centralbl. f. Gynækologie*, 22, 1887), has recently employed it in three more cases with good results. The remedy has also been given by Laferla and Cazanue with similar results.—*Centralbl. f. Gynækologie*, 39, 1890.—*Norsk Magazin for Lægevidenskaben*, 11, 1890.

CATARRH SNUFF.

R	Finely powdered cubebs.....	ʒi.
	" " borax.....	ʒij.
	" " camphor.....	ʒij.
	" " alum.....	ʒij.
	" " soap bark.....	grs. vj.—M.

INCONTINENCE OF URINE.

R	Tinct. nucis vomice.....	f ʒvj.
	Ext. damianæ fl.....	f ʒijss.
	Glycerial.....	q. s. ad f ʒijss.—M.

S.—ʒ j three times a day, after meals, in a wineglassful of water.

AN ANTI-NEURALGIC MIXTURE.

Dr. Hightoner employs the following:

R	Bromide of ammonium.....	ʒss.
	Salicylate of sodium.....	ʒss.
	Tinct. hyoscyamus.....	ʒss.
	Water.....	ʒss.
	Syrup.....	ʒss.

A teaspoonful every thirty minutes until the pain disappears, without exceeding four teaspoonfuls.

—*Lo Sperimentale*, No. 1, 1892.

PERMANGANATE OF POTASSIUM IN DIPHThERIA.

Dr. Netetzky says that his twenty-two years' practice convinced him that the best treatment of faucial diphtheria consists in an energetic use of permanganate of potassium.

The drug should be administered in the shape of paintings and gargle. The following strong solution should be employed:

R	Potassi permanganatis.....	ʒj.
	Aque destillate.....	f ʒij.

M. Sig.—To paint the affected surface every three hours.

For gargling, which is to be repeated as often, a teaspoonful of the same solution should be mixed with a tumblerful of boiled water.

In those cases in which the child is unable to gargle, the following mixture should be given internally:

R	Solutionis hydrogenis superoxy.....	f ʒij.
	dati, two per cent.....	f ʒij.
	Glycerine.....	f ʒij.

M. Sig.—A teaspoonful every two hours.

—*Medical Record*.

COMEDONES.

Blondel's formula is as follows:

R	Magister bismuth.....	ss	grams 3.
	Acid. bor. pulv.....	ss	grams 3.
	Rad. ratanh. pulv.....		gram 1.
	Tragacanth.....		grams 3.
	M. A dusting powder.		

—*Deutsche Med. Zeitung.*

PAINFUL MENORRHAGIA.

The following is recommended in menorrhagia with pain:

R	Tinct. hydrast. canad.....	f 3 j.
	Extr. hydrast. canad. fl.....	f 3 iv.
	Sig.—Twenty drops three times a day.	

—*Raccoglitori Medico*, 11, 1890.

A FORMULA FOR SYCOSIS.

Dr. Rosenthal (*La Semaine médicale*, No. 11, 1892) speaks highly of the following salve in the treatment of sycosis:

R	Tannin.....	grams 2.
	Lactate of soda.....	grams 5.
	Oxide of zinc.....	ss
	Powd. starch.....	ss
	Vaseline.....	grams 40.

Apply this salve twice a day upon the previously well-shaved parts.

ACUTE ANGINA.

R	Sodium benzoate.....	gr. x.
	Tincture of benzoin.....	f 3 ss.
	Infusion of rose leaves.....	f 3 ss.
	M. Sig.—Use frequently as a gargle.	

—*L'Abeille Méd.*

TRAUMATIC TETANUS.

Dr. Mayer, of Amberg, reports a cure from the use of a mixture containing in each dose:

R	Muriate of morphine.....	1-65 grain.
	Chloral hydrate.....	1/4 grains.
	Bromide of sodium.....	1/4 "
	Sig.—To be taken three to six times a day. Fifteen grains of morphine were taken in all.	

HÆMOPTYSIS.

L'Union Médicale states that Bamberger recommends the following prescription in cases of hæmoptysis:

R	Powdered alum.....	gr. xxx.
	Hydrochlorate of morphine.....	gr. 1/4.
	Powdered white sugar.....	ss.

Make into six powders, and give all of them in divided doses, in the space of three or four hours, in case of profuse hæmoptysis with cough.

Keep the patient absolutely quiet, and apply mustard-plasters and external heat to the extremities.

FOR OTORRHEA.

R	Acid. bor.	ss.
	Glycerin.....	ss.
	Aque.....	ss.

S.—Instil a quantity sufficient to fill the auditory canal three or four times daily.

TREATMENT OF DIPHThERIA.

Gaucher (*Gaz. des Hôpitaux*, 1891, No. 122) recommends the local application of the following formula in the treatment of diphtheria:

R	Acid. tartaric.....	gr. xxiv.
	Acid. carbolic.....	ss.
	Spts. vini rect.....	f 3 iv.
	Oil ricini.....	f 3 vj.
	Camphore.....	ss.

The membrane upon the affected surfaces is first gently removed. The application is then carefully made. After an interval of ten minutes, the parts are generously irrigated with boiled water, or a 1 or 2 per cent. solution of carbolic acid. If symptoms of laryngeal obstruction arise, a 2 per cent. solution of carbolic acid is constantly vaporized in the sick-room.—*Centralbl. für die gesammte Therap.*, x, 3, p. 172.

TREATMENT OF LUPUS ERYTHEMATOSUS OF THE FACE AND EYELIDS.

Dr. Brocq (*Le Bulletin médical*, No. 17, 1892) advises the application of the following salve:

R	Salicylic acid.....	dgms. 5.
	Lactic acid.....	8.
	Resorcin.....	7.5.
	Oxide of zinc.....	grams 2.
	Pure vaseline.....	17.

Pyrogallie acid is a topical application of great service in the treatment of lupus erythematosus. It has been employed in the most different manners. He uses the following:

R	Salicylic acid.....	gram. 1.
	Pyrogallie acid.....	grams 2.
	Pure vaseline.....	ss.

This salve is applied at night, and is well tolerated; during the day one may use the resorcin salve.

SUBSTITUTE FOR MUCILAGE OF ACACIA.

The following mixture was recommended by Mr. H. D. Sykes, at the last meeting of the Wisconsin Pharmaceutical Association, as a substitute for mucilage of acacia for technical purposes:

R	Dextrin, white.....	6 ounces.
	Acetic Acid, dilute.....	1 ounce.
	Oil of cloves.....	10 drops.
	Glycerin.....	1 ounce.
	Water.....	to make 16 ounces.

Mix the dextrin thoroughly with 6 ounces of cold water, add 8 ounces of boiling water, boil five minutes, stirring constantly; add hot water sufficient to make 14 ounces. When it is cold, add the acetic acid, oil of cloves, and glycerin. The oil must be thoroughly mixed with the remainder.

THE MEDICAL and SURGICAL REPORTER.

ISSUED EVERY SATURDAY.

DIRECT COMMUNICATIONS TO

P. O. Box 843, Philadelphia, Pa.

EDWARD T. REICHERT, M. D., Editor.

(Professor of Physiology, University of Penna.)

BUSINESS OFFICES:

29 to 35 North Tenth Street, Cor. Filbert.

EDITORIAL OFFICE:

Southeast Cor. 36th and Woodland Ave.

TERMS: Five dollars a year, strictly in advance, unless otherwise specifically agreed upon. Sent three months on trial for \$1.00.

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LEADING ARTICLES.

THE MANUAL TREATMENT OF NOCTURNAL ENURESIS.

Nocturnal enuresis, or bed-wetting, is one of the most frequent troubles met with in young children. Not only in sickly, delicate, rachitic and scrofulous children, but those which are in vigorous health suffer from this weakness. Unfortunately the treatment of this most annoying ailment is far from always being crowned with success. Various drugs have been used for the purpose and occasionally internal medication is productive of good results, nuxvomica and belladonna being the foremost among the drugs thus used, although recently the spiced tincture of rhubarb has been employed with decided success. Then again the local treatment with the Faradic current has not infrequently given still better results.

However, neither one treatment nor the other seems productive of permanent good. It is for this reason that the mechanical treatment of nocturnal enuresis, as suggested by Dr. Julius Csillag, will be welcomed by the profession, both for its comparative simplicity and its asserted efficacy.

Csillag takes the same view of this affection as Ultzmann, viz., that it is caused by a lack of innervation and weakness of the sphincter of the bladder. The cases which Csillag has successfully treated with this mechanical method included many which had resisted all other treatment, both internal and local.

The method was originally suggested by Thure Brandt—whose contributions in the field of massage are so well known—and Csillag has slightly modified it. Briefly described it as follows:

1. The patient is placed in the lithotomy position, and the physician introduces his right forefinger into the rectum, and seeks the urethra below the symphysis. Then following its course in the direction of the neck of the bladder, presses the urethra

against the bone and executes a slight vibrating pressure with the finger. This is repeated five or six times. In the meanwhile the fingers of the left hand press externally in the direction of the internal finger and simultaneously execute this vibratory pressure. This act which, as has been said, is repeated five or six times is designated by Csillag as pressure of the vesical sphincter. That the bladder should be emptied previous to this part of the treatment is obvious.

2. The patient is kept in the same position, and the physician, holding his hand parallel with the axis of the body, presses deeply into the pelvis with the finger tips and again executes a vibratory pressure. This is repeated twice or thrice, and is called by Brandt a pressure of the hypogastric plexus.

3. The patient is laid upon the back with the limbs outstretched and lying parallel to each other. The physician then grasps the patient by the ankles and pulls them apart, encouraging the patient, meanwhile, to endeavor to resist his movements. Now the patient brings his legs together, the physician resisting the movement.

4. The patient is again placed in the lithotomy position, but with his knees together. The physician stands at the side of the patient and presses the knees apart, the patient meanwhile offering resistance. Then the patient brings his knees together while the physician offers resistance. By means of these last two exercises the adductors and abductors of the thigh and the recti abdominales muscles are brought into play, but simultaneously also the muscles of the floor of the pelvis are exercised. The anal sphincter contracts forcibly, and with it the vesical sphincter, owing to the synergism of the two muscles.

5. The patient stands, bending slightly forward, and resting his hands against a table crosses his legs, and then upon command of the physician, contracts the anal sphincter as though he were endeavoring

to restrain a movement of the bowels. This exercise which can be intrusted to the care of the parents of the child, should be repeated four or five times in succession and repeated hourly. It tends to greatly strengthen both the anal and vesical sphincters.

6. The physician then stands to the left of the patient, and with the tightly closed fist strikes the sacrum. The movement of striking should proceed from the wrist only. The striking of the sacrum slightly excites the nerves leading from the spinal column to the organs in question.

While the technique of this method seems at a first glance to be complicated and perhaps tedious, yet in reality is most easily carried out, and is excellently borne by the little patients, who seem to look upon it more as an amusement than otherwise. The beneficial results are not long in becoming manifest, and if continued recovery will be complete and permanent.

In conclusion we would say that very frequently both parents and physicians are apt to regard nocturnal enuresis as a habit and not a weakness, and commonly endeavor to break the child of the trouble without any treatment other than admonition and punishment. Such a course is grossly unjust and brutal.

Finally, we would draw attention to a cause of enuresis, that is a long foreskin. Not only is phimosis in children a frequent cause of this difficulty but often leads early to masturbation. If this defect exists circumcision is necessary.

Csillag's method is based upon sound physiological and hygienic principles and is well deserving of thorough trial.

DIABETES INSIPIDUS.

Professor DaCosta prescribed the following to stop the large flow of urine:

R Antipyrine gr. v.
Quinine sulph. gr. ij.-iii.

To be given twice a day, and if this does not act satisfactorily, increase to three times a day.—*Col. and Clin. Record.*

BOOK REVIEWS.

THE INTERNATIONAL MEDICAL ANNUAL AND PRACTITIONER'S INDEX FOR 1892. Edited by P. W. Williams, M.D., assisted by a corps of thirty-two collaborators in this country and Europe. Illustrated. Price, \$2.75. New York: E. B. Treat.

This book of reference has reached its tenth annual edition, and the list of thoroughly competent men by whom it has been compiled is sufficient evidence of the reliability of the work performed. The volume is intended especially as a complete résumé of medical treatment, particularly with regard to the many new remedies that have made their appearance since the last edition of the book, and to new modes of therapeutics by means of old remedies.

It is a well executed attempt to define as clearly as possible the real medical progress of the past year in every department of therapeutics. It is divided into three parts, the first of which deals with new remedies, with a review of their therapeutic applications; the second part is devoted to new treatment, and contains a wide range of information regarding the advances made in 1891; the third part includes reports of progress in bacteriology, medical photography, sanitation, and also details of the improvements made in pharmaceutical preparations, medical instruments and appliances.

Although we wish that more references had been incorporated in certain important departments of the book, we regard it as largely fulfilling its claims as most comprehensive review of new drugs and new treatment, and that to the general practitioner few books will be more welcome and serviceable.

TRANSACTIONS OF THE MEDICAL AND SURGICAL FACULTY OF THE STATE OF MARYLAND. Ninety-third annual session. Held at Baltimore, Md., April, 1891. Baltimore: Griffin, Curley & Co.

This edition of the transactions contains a very full report both of the Semi-Annual Meeting held at Cambridge, Md., Nov. 1, 1890, and the regular meetings held in Baltimore during the following April. At both meetings numerous excellent papers were read, so that the volume will be a welcome contribution. The Annual Address was delivered by Prof. Wm. H. Welch, the brilliant pathologist of Johns Hopkins University, who chose for his

subject "The Causation of Diphtheria"—a most interesting topic, and dealt with in his masterly style. The article should be widely read because it gives the best that has been written during the last decade on the subject of the bacillus diphtheriæ.

Among other interesting papers we would mention particularly the following: "Eye Diseases of the Unborn" by Dr. Julian Chisholm; "Obstetrical Antiseptics" by Dr. J. Edwin Michael; "Treatment of Diphtheria" by Dr. Joseph T. Smith; "The Relation of Albuminuria to Puerperal Eclampsia;" and a valuable statistical paper by Dr. Randolph Winslow on "Innominate Aneurism."

If all medical contributions were passed upon by a competent body of educated physicians very much less worthless reading matter would appear in our libraries to confuse and mislead the searcher after truth. The publication committee of any large society occupies a most important position, and should freely exercise their right to exclude from publication articles which have not a distinct intrinsic value. Additional care in the admission of members seems also imperative as a preventive measure. At the present rate at which members are promiscuously added to our societies, and at which articles are appearing upon every conceivable topic, it rather startles one to contemplate where the future will land the bibliophile.

THE PEPSIN STANDARD ADVANCED.

There are many varieties of pepsin in market, differing widely in purity, activity and adaptability for therapeutic use.

Whether pepsin be prescribed with success or failure depends on its quality. The physician prescribing pepsin should demand in his prescription a pepsin product which he has convinced himself is pure and active and can be relied upon.

By prolonged investigation of digestive ferments the standard has been again and again advanced. It is announced by a leading pharmaceutical firm that they have succeeded in making a pepsin capable of digesting 4,000 times its weight of coagulated egg albumen under the conditions of the pharmacopœial test.

This product is prepared by a new and original process which renders it aseptic, free from odor, agreeable in taste to the most sensitive palate.

PERISCOPE.

THERAPEUTICS.

THE ACTIONS OF ERGOTINE AND ERGOTININE UPON THE CIRCULATION AND THE MOVEMENTS OF THE STOMACH.

From a study of the subject, made by E. Wertheimer and Magnin (*Arch. Physiol. Norm. Patholog.*, January, 1892.) the following conclusions have been arrived at: 1. Intravenously injected, Yon's ergotine, like Bonjean's ergotine, causes a marked lowering of the arterial pressure, often preceded and followed by an increase. The simultaneous diminution of the volume of the kidney, shows that the fall of the pressure is not due to a vaso-motor dilatation. The direct examination of the intra-ventricular pressure indicates that the fall is dependent upon a weakness of the cardiac contractions; 2. A hypodermatic injection of both ergotines produces an elevation of the arterial pressure, without a previous fall; 3. When injected into the blood, both ergotines produce marked contractions of the stomach; the same results are obtained, though less pronounced, when the drugs are administered subcutaneously; 4. Tanret's ergotine, when given intravenously, causes a rise of the blood-pressure and a slowing of the heart; but it does not seem to act upon the stomach, either in small or moderate doses.

CHLOROFORM IN THE TREATMENT OF TYPHOID FEVER.

Paul Werner (*St. Petersb. Med. Woch.*, 1892, No. 3.—*Revista de Ciencias Médicas de Barcelona*, March 25, 1892.) makes a comparison between the character of the typhoid fever of to-day and that exhibited by the disease 20 years ago. He then showed how the malady can be treated by means of chloroform, condemning, in passing, the employment of iodoform which he thought would have given good results. The author came to use the anæsthetic in the treatment of typhoid fever, after the suggestion of a German physician, and following the results obtained from the experiments of Behring and Salkosake on the action of chloroform as a disinfectant. Werner administers the drug in an aqueous solution, in the strength of $\frac{3}{4}$ per cent., of which he gives one or two tablespoon-

fuls every hour, day and night, until the symptoms subside; then the dose is reduced to one tablespoonful, and afterwards this latter quantity is given only every 2 or 3 hours until deffervescence is established. Under these circumstances the patient is allowed only a tablespoonful during the day, in the afternoon. The author has employed this method in 130 patients in the course of 13 months, and has never observed any disagreeable effects. Notwithstanding that the remedy may be considered as only symptomatic, Werner believes that success in the treatment of the disease in question could be insured, by using the anæsthetic as described, during the first days of the disorder; and that even in the latter stages of the disease, chloroform does good. The drug acts primarily by relieving meteorism and the diarrhoea; it likewise prevents cerebral phenomena, bed-sores, relapses and other disagreeable symptoms observed during the period of convalescence.

THE TREATMENT OF BURNS BY EUROPHEN.

Dr. Siebel (*Berlin. Klin. Wochenschr.*, No. 8, 1892) speaks as follows on this subject: I have employed euphphen for almost one year in the treatment of burns and injuries resulting from corrosive substances, which, as is well known form the main contingent of accidents at chemical manufactories, and have been for some time past treated almost exclusively with iodoform. I have treated, with equally good results, about thirty patients suffering from burns and the effect of caustics from the slightest forms to the third degree and arising from all sorts of injurious agents [as for example, hot soda, lye, boiling glycerine, sulphuric and hydrochloric acid, burning alcohol.] My method is this: Apply the euphphen in the same manner as is customary to use iodoform; that is, after cleansing the parts, opening the bullæ, etc., cover the burned places lightly with euphphen powder, then apply a dressing of sterilized gauze and cotton and fix with bandages. If the burned areas are extensive or could not be readily covered with the powder, I dress the wounds with 10 per cent. gauze, renewing the dressing as often as necessary. Under this treatment exuberant granulations are formed, and the cicatrix is firm, yet elastic. The only disadvantage of this dressing occa-

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sionally observed was the firm agglutination of the gauze to the wound, and this could not be completely obviated by interposing a layer of gutta percha paper. In consequence of this adhesion the exuberant granulations were frequently torn on renewal of the dressings and slight hæmorrhages produced.

To avoid this disagreeable feature I made use of euphphen in the form of ointments, and at first 10 per cent. strength. As the latter, however, produced irritation in some instances, and in one case a slight eczema, I diminished its strength and finally adopted a 3 per cent. ointment with vaseline and lanolin (euphphen 3.0 grammes, ol. oliv. 7.0 grammes; adde vaselin. 60.0 grammes, lanolin 30.0 grammes). I obtained the best results from this ointment, and what was especially remarkable was the marked diminution of the secretions. Owing to the latter effect it was found possible to leave the dressings in place three or four days and to renew them easily and without pain (many patients were enabled to continue work under use of a starch dressing). Severe burns of the third degree healed completely after three or four dressings. The longest period of healing (twenty-two days) was observed in a case of severe injury from hydrochloric acid, extending from the elbow to the wrist over a breadth of five centimeters. It should also be noted that euphphen ointment relieved the pains from the moment it was applied. Unfavorable effects or symptoms of poisoning have been never observed by me, aside from the irritation produced by the stronger ointments. In children euphphen can also be employed without risk, since it may be regarded as innocuous, at least in the doses which obtain here. I have myself taken internally for a period of three weeks from 5 to 8 grammes of a 20 per cent. solution in oil every day, that is about 1½ grammes of euphphen daily without experiencing the slightest discomfort, or even as much an impairment of appetite.

On the ground of these observations I would highly recommend the 3 per cent. euphphen ointment in burns of all degrees of severity. The results are better than the use of iodoform, and besides the absence of all disagreeable odor, there is no danger of the toxic effects which, although fortunately rare, are sometimes observed from the application of iodoform."

MEDICINE.

EXPERIMENTAL PANCREATIC DIABETES

According to the *Mercure Médical*. September 30, 1891, before the French Academy of Medicine, Dr. Lancereux exhibited for Dr. Thiroloix a dog which had undergone extirpation of the pancreas. The animal presented the typical condition of pancreatic diabetes, or what the French call thin diabetes. This condition had developed in thirty-five days after the operation. Glycosuria appeared within two days of the operation, ceasing twice for a period of one week, then was replaced by azoturia. In order to make the animal really ill, complete ablation of the pancreas was necessary, for simple ligation of Wirsung's canal had caused him no inconvenience whatever. The subject of pancreatic diabetes was then discussed by Drs. Germain Sée, Lancereux, Ollivier, and Semmola. The foregoing interesting experiment Dr Sée considered a valuable addition to those made by Minowski, Mering, Hédon, and Lépine. It confirmed Dr. Lancereux's earlier studies and discovery of the clinical picture of pancreatic diabetes. As the function of the pancreas upon general nutrition was as yet unknown, the substitution of azoturia for glycosuria in this experiment proved highly interesting. Not all "thin" diabetics could be called pancreatic. Three recent autopsies made by the speaker were negative in this particular. Dr. Sée recalled to the Academy his own experiments, made by the introduction of fluorhydric acid. The remedies considered panaceas in the treatment of diabetes, Vichy and opium, were tried. Vichy proved unavailing, and opium hurtful. Dr. Sée strongly recommended antipyrin, and spoke of Dr. Panas's case that under the influence of this drug supported well the extraction of a cataract. In reply, Dr. Lancereux said that pancreatic diabetes was a more precise term than "thin diabetes." There were several forms of diabetes: the fat form, or the diabetes of lithæmics that become fat at the end of the period of growth, with but little glycosuria, who were but slightly diabetic, slightly polyphagic, and who often live to the age of eighty. With these, diabetes was more a manner of being than a disease. Then there was pancreatic diabetes, and traumatic diabetes (Claude Ber-

nard). Dr. Semmola objected to the interchangeability of the terms glycosuria and diabetes. The first was a symptom merely; the latter a terrible disease that might be nervous, traumatic, lithæmic, or alimentary in origin. There was either insufficient destruction of sugar or excessive production. Dr. Sée replied that, while agreeing with his confrère that an error in nutrition lay at the bottom of all diabetes, he thought the apparent fine condition of certain persons suffering from glycosuria should never mislead as to the gravity of the case, and referred to Dom Pedro, the late emperor of Brazil, who set up a serious gangrene of the foot while at Vichy, by simply trying to cure a corn. In summing up, Dr. Lancereaux said that slight and temporary diabetes was the same thing as permanent traumatic diabetes that soon became fatal, the difference lying solely in the degree of gravity, as in variola and varioloid. Earlier in the discussion Dr. Ollivier spoke of hereditary diabetes and of nervous emotional diabetes. The latter he had seen develop instantaneously upon a sudden loss of fortune. Fifteen years later the patient died of diabetic pneumonia.

THE POISON THEORY AND PHAGOCYTOSIS.

SANARELLI says (*Centralb. f. Bakt. u. Parasit.*, October 31st, 1891) he showed in Nos. 14 to 16 of the same journal how the lymph from the posterior lymph sac of the frog possessed the property of rendering anthrax foci inert whether these latter contained spores or not. Pieces of the spleen taken from animals dead of anthrax and introduced beneath the frog's skin, or cultivations brought into contact with this lymph (free from leucocytes), lose their virulence. The lymph acts, not upon the vitality, but on the virulence of these organisms. Experiments have not shown that the lymph is a true and specific antiseptic capable of destroying the anthrax foci, but that it is an unfavorable cultivation medium. The organisms rapidly regain their virulence when transferred to a suitable medium. All are agreed that the cells quickly seize upon the bacteria, for they may be seen containing bacteria three to four hours after inoculation. Even while in the cells the organisms may excrete toxic substances, which irritate the heat centres and cause a rise of tem-

perature. Metchnikoff has certainly seen movements in the bacilli in these cells, and this must be evidence of life. He has also seen the partly taken up bacilli grow and capable of forming virulent cultures. The question arises as to the value of phagocytosis as compared with the bacteria-killing properties of organic fluids in refractory animals. Sanarelli says that he cannot believe, with the exclusive supporters of this poison theory, that the leucocytes can only take up the bacilli when these are dead, nor yet with the extreme partisans of phagocytosis that there is a veritable conflict between the leucocytes and the bacteria. He prefers to think that, owing to the unfavorable soil, the pathogenic organisms have their growth checked, and that the leucocytes gradually take them up and remove them from the body. This confirms Petruschky's view that the bacteria-killing action is able to explain of itself, and without the least help from the leucocytes, the immunity of frogs against anthrax.—*Brit. Med. Jour.*

SURGERY.

PREHISTORIC TREPHINING.

Although looked at from a modern standpoint the knowledge of surgery possessed by the ancients was of the most rudimentary character, it must not be forgotten that we are indebted to them for many of the operative procedures which the surgeon of the present day is called upon to perform. Necessity, as the saying goes, is the mother of invention, and it is certain that the ancient medical man, although profoundly ignorant of pathology was frequently led by common sense reasoning—some might call it intuition to devise operations, the knowledge of which became lost in the course of time. A familiar instance of this is the operation of rhinoplasty, which was practised from a remote period in India and owed its invention to the custom of punishing criminals by cutting off their noses. Notwithstanding its ancient origin, however, rhinoplasty was not employed to any extent in Europe until the present century. An interesting chapter to the history of ancient surgery has been recently contributed by Professor Hal C. Wyman, of Detroit. In a paper published in the *American*

Lancet, Dr. Wyman describes a skull which was exhumed from a mound on the banks of the Detroit River, and which, in his opinion, presents evidences of having been trephined for surgical purposes. Through the top of the cranium three holes had been bored, bearing such relations to each other that lines drawn connecting them would have formed a triangle. The apertures are remarkable for the smoothness of their sides and their almost perfect circular circumference. Dr. Wyman thinks that no stone or flint instrument could have produced them, but that the material used was obsidian, a species of very hard lava, with the properties of which the ancients were acquainted. From the same mound which furnished this interesting specimen four other skulls had been exhumed at different times, and two of these were also perforated. An investigation of this subject by the author revealed that a number of such skulls had been found in the western part of this country, but especially in Michigan, Illinois and Ohio, while numerous specimens have been discovered in nearly every country of Europe, in Asia Minor and Algeria. It is noteworthy that there still exists a race in Algeria called Kabyles, who employ trephining for cranial fracture making use of instruments which, though of the most simple pattern, are well designed for the purpose. The question of surgical interest is whether these crania of prehistoric races were trephined before or after death. Dr. Wyman states that the perforated skulls in Europe and Asia Minor bears better evidence of trephining as a surgical proceeding than those of America, many, and perhaps most of which appear to have trephined post-mortem. It is generally believed that the trephining was performed for religious rather than surgical purposes, but as the author pertinently remarks, if this were true it is strange that more perforated skulls have not been found since religious observances are practised commonly by the masses. The fact that the openings usually show no signs of cicatrization is, in the author's opinion, no valid objection against the view that they were made for surgical purposes, since the operation may have been resorted to too late to prolong life until repair could establish permanent traces. Moreover, the perforations are so small that, if the operation was successful, the

openings would close entirely in a few weeks, leaving no traces which would be likely to be detected by any one but a skilled archaeologist. The author, therefore, concludes that the valley of the Great Lakes once contained a race of people who practised surgical trephining, and this view is in keeping with the teaching of Broca, the foremost authority on this subject, who says that in the stone age young children were frequently trephined for internal maladies.

THE TREATMENT OF STRICTURES DUE TO INCOMPLETE RUPTURE OF THE PERINEAL URETHRA.

Guyon, in a clinical lecture at the Hospital Necker (*Le Mercredi Médical*, 1891, No. 51), spoke of strictures following incomplete rupture of the deep urethra, and exhibited five cases.

These cases are characterized by rapid formation of the stricture, with a persistent tendency to recurrence. The contractile power of the new tissue is never entirely overcome.

In case of complete rupture of the urethra, the rule is to incise the perineum at once, without making any attempt at catheterization, and to join the two ends of the urethra after having passed a sound. Guyon has been a strong advocate of this true surgical principle, and advises in addition the immediate sewing of the ends of the urethra, if they are not too irregular. If the ends are not sufficiently even they may be resected.

This treatment would probably be satisfactory in cases of partial rupture of the urethra, if done at once; but when one is compelled to operate for conditions due to lesions already formed it is better to remove the cicatricial constriction by partial resection of the urethra. The results, both primary and remote, are satisfactory in the highest degree, the more so when compared with other plans of treatment, including external urethrotomy.

The object of the resection of the urethra is to remove the hard, thick, and retractile cicatrix and to obtain linear union, with the result of a smooth scar. Total primary union is frequently obtained—even more frequently than could be expected—and uninterrupted healing takes place in spite of slight contamination by urine.

OBSTETRICS.

PUERPERAL SEPTICÆMIA FROM MEPHITIC AIR.

Guéniot (*Bull. de l'Acad. de Méd.*, 3rd series, vol. xxvii, No. 9) read before the Paris Academy of Medicine on March 1st, 1892, a paper on this subject, which raised a very active discussion. It was based on four cases, in which the mothers all recovered after running great peril; the children were all born alive. The house where the patients lived was in each case malodorous. In the first case, the poisonous air from an untrapped sink pipe in a dressing room attached to the patient's bedroom. A similar insanitary arrangement existed on each floor. In the second case, a filthy privy on a staircase close to a large library room was the source of infection; the patient's apartment was on the other side of the library. In both these cases, the forceps was used with every precaution; Guéniot has employed instruments repeatedly without any similar accidents. In the remaining cases, no forceps was required; the mephitic air came from a privy in the third, and from a ventilating pipe connected with a cesspool in the fourth. Free carbolised intrauterine injections and other precautions saved the patients. Guéniot declared that mephitic poisoning during pregnancy occurred in the respiratory tract; after pregnancy it entered through raw surfaces contaminated by liquids and solids already infected by the poisoned air. The septicæmia so produced was not of a suppurative type; its chief focus was the uterine cavity, where the septic vibrios met, in fluids holding the products of mephitism, a first-rate cultivating medium. M. Alphonse Guérin, who claimed to have discovered the germ theory of sepsis many years before the modern antiseptic doctrines were first promulgated, and M. Charpentier alike scouted the theory of infection through the lungs. That way of infection only occurred in paludal fever. Had the mephitic poisoning occurred through the lungs in M. Guéniot's cases, the patients would have been taken ill during pregnancy, not after delivery; and M. Guéniot did not explain how it was that the other inhabitants of the houses where the patients lived managed to escape infection. M. Charpentier considered that injections were insufficient,

the curette should be used as well, but M. Guéniot maintained that the curette often made these cases worse. The septic symptoms only appeared after delivery because then a far larger dose of the poison was taken into the system than before.—*Brit. Med. Jour.*

AN OBSTETRICAL BUNDLE.

This bundle I have found very useful. I have such a bundle prepared for every obstetric case, and its cost, seventy-five cents, is more than made up by the saving of time and subsequent visits. It contains the following:

1. One square yard of rubber cloth to be placed under the patient's hips and thighs—rubber side up, of course.

2. One square yard of cotton flannel to be placed on top of the rubber, between it and the patient's body. In this way I make sure of having the bed protected and kept clean, and an aseptic environment, and the rubber can be quickly arranged to carry off the fluids into a suitable receptacle in case of operative procedures.

3. A number of pieces of cheese cloth to use as small towels, and also when dampened with bichloride solution, as pads for the vulva.

4. A new and clean nail brush for each case. These brushes cost three cents, and hence one can afford a new one each time.

5. Safety pins.

6. A narrow bobbin, consisting of three strands, for ligating the umbilical cord.

7. An obstetrical eye bandage. This consists of a strip of cheese cloth, the two edges of which are rolled in and then doubled over a second time. While waiting for the pulsations of the cord to cease I wipe out the baby's eyes, and wrap this bandage around the head and eyes, and pin it. When this is not done the child often rubs its dirty fingers into the eyes before the attendants have had time to wash the child. Since I have adopted this plan I have never had any cases of ophthalmia neonatorum.

8. A small wooden vial containing tablets of bichloride of mercury. I prefer these small ones to the larger size, as they are just sufficient for each dressing without splitting the tablet.—G. E. Abbott, M. D., in *Post-Graduate*.

THE TRANSLUCENCY OF SOLID TUMORS.

Dr. Poncet (*Bulletine de l'Académie de Médecine*) has recently called attention to the fact that translucency is not a characteristic of fluid tumors only, but that this property is shared by certain solid formations. Thus he had noticed translucency in four cases of lipomata of the hand, forearm and axilla, in chondromata of the bones and soft parts, in fungous synovitis, in dermoid cysts with solid contents, etc. It follows from these observations that the mere translucency of a tumor is no positive indication of its fluid character and can therefore be regarded as only of comparative diagnostic value. But even in cases where there is no doubt as to the presence of a fluid accumulation, the fact that it is translucent does not throw much light upon its nature. The contents may be more or less turbid or more or less admixed with blood, without arresting the passage of the rays of light. Dr. Poncet has observed this several times in cases of hydro-hæmatocele and other cysts with bloody contents, and in a case of hæmatoma of the ear upon which he operated the tumor was entirely translucent. He thinks therefore that the translucency of a tumor depends chiefly upon its size and especially upon its thickness.

GYNECOLOGY.

EUPHORIN IN GYNÆCOLOGICAL PRACTICE.

L. M. Bossi (*Rif. Med.*, December 15th. 1891) reports the results of some clinical experiments with euphorin made by him in obsteric and gynæcological cases. He employed it in powder in twenty cases of ruptured perineum, and found that it promoted rapid healing both in slight cases and in more severe lacerations where sutures had been required. He also used it as a dressing to the stump of the umbilical cord in twenty-one newborn babes. In no case did suppuration take place, nor was there any sign of the drug having been absorbed. In none of the cases was there any appearance of icterus neonatorum. In twenty-nine gynæcological cases euphorin was employed as a fine powder, applied by means of a special atomiser (vaginitis, ulcerations of the os, cervicitis with abrasions of the portio vag-

inalis and parenchymatous cervico-metritis) or small pessaries about 4 centimetres in length and containing 40 to 50 per cent. of euphorin, which were introduced every two or three days into the uterine cavity (in cases of acute and chronic endometritis). In both these classes of cases the results of the treatment were satisfactory, and Bossi concludes by saying that his experience leads him to think that euphorin acts both more efficaciously and more rapidly than any other substance hitherto in use, not excepting iodoform. —*Brit. Med. Journ.*

URETHRAL CARUNCLE.

Christopher Martin, writing in the *Birmingham Medical Review*, thinks this neoplasm has hardly received the attention it deserves. He classifies it among the vascular tumors. It is exceedingly doubtful whether the connection between the majority of causes usually assigned to it and the disease is more than accidental. On the other hand, he thinks it likely that in many cases the exciting cause is a highly acid or irritating condition of the urine. Uric acid is peculiarly responsible for many cases. At the end of each act of micturition a drop of highly concentrated urine loaded with sharp crystals is left at the meatus. The crystals settle on the mucus membrane, and possibly lodge in the glandular crypts which are so abundant there, and the repeated irritation of their presence determines the new growth. This irritation is partly mechanical, partly chemical. Whether or not it actually causes it, certain it is that, after the growth has developed, a highly acid urine frightfully aggravates the patient's sufferings. The great symptom is pain. The suffering is out of all proportion to the size of the growth. The distress is present on walking, passing urine, during coition or at any time the parts may be impinged upon. The diagnosis is made complete on inspecting the external genitals. On drawing apart the labia, there is seen at the meatus urinarius, or just within it, a small, bright crimson growth. It varies in size from a pin's head to a cherry, but is generally about the size of a pea. It is usually situated on the posterior lip of the meatus. It is very soft and friable, and bleeds readily on manipulation. If care-

fully prepared sections of a caruncle are examined with a moderate power, the growth is seen to consist of very numerous and widely dilated capillary loops imbedded in a delicate connective tissue stroma. The treatment consists in the complete removal of the growth. The patient is anesthetized and placed in the lithotomy position. An elliptical incision is made in the mucus membrane of the vestibule around the meatus, and about one-sixth of an inch distant from it. By means of fine scissors this incision is deepened, and the entire lower end of the urethra, for about one-third of an inch of its extent, is separated from the surrounding tissues. The piece of the urethral canal thus isolated is gently drawn down and removed by a snip of the scissors. The edge of the divided urethral mucous membrane may then be united to the edge of the divided vestibular mucus membrane by a few sutures, or the raw surface may be allowed to granulate. Cicatricial stricture may be prevented by the regular passage of a soft bougie. If a stricture should form it may be easily remedied by slitting the urethra up for about a third of an inch. The prognosis as to the likelihood of recurrence after removal should be guarded.

HYDRASTININ.

Strassmann (*Deutsche med. Wochenschrift*, No. 47, 1891) employed this drug, both per os and by subcutaneous injection, in twenty-seven gynecological cases. In three of the cases the length of time under observation was too short to draw any conclusions. Of the remainder, six received injections (ten per cent.) and eighteen took the drug by mouth. The largest dose by mouth per diem was 0.15 and the maximum injection 0.2. The drug per month was given in the form of pearls 0.025, and by injections 0.05 to 0.1. From forty to sixty pearls were taken in from two to three weeks. The indications were: menorrhagia, after difficult operative labors, endometritis, chronic parametritis, subserous fibroids, metrorrhagia due to some nervous origin, hydrosalpinx, tubercular salpingitis, perimetritis, enlarged ovaries, subinvolution of the uterus post partum, post abortum, atrophy of the uterus, myoma, and subinvolution uteri without hemorrhage. No other treatment except rest in bed, which was en-

joined in all of the cases. In three cases, tubercular peritonitis, salpingitis, and in one case in which a portion of a retained placenta was afterward removed, the drug proved useless. In the remaining twenty-one cases the action was decidedly beneficial. Hemorrhages were entirely controlled in from two to three days, menstruation less profuse, not lasting so long, and usually postponed for a few days.

PEDIATRICS.

SURGICAL TREATMENT OF TUBERCULAR PERITONITIS IN CHILDREN.

Alexandroff (*Rev. Mens. des Mal. de l'Enf.*, September, 1891), reported the following case. The patient was a girl three-and-one-half years of age. Two of her paternal uncles were tubercular. She was born at term and nursed by her mother. At the age of two years she had whooping-cough, which lasted five months. A short time afterward she was attacked with diarrhoea, and the belly began to enlarge and show clear evidence that it contained fluid. The heart and lungs were normal, the liver and spleen were not hypertrophied the urine was normal. A diagnosis of tubercular peritonitis was made and the child was kept under observation one month. At the end of this period she was worse, and the abdominal section was performed. Nearly two litres of transparent yellowish-green fluid were removed from the abdomen. The peritoneum was injected and tubercles were scattered over it. There was no irrigation, the wound was sutured, a drainage-tube was used, and iodoform dressings were applied. At the end of three weeks fever and diarrhoea recurred and the fluid began to accumulate again. The wound was reopened and the peritoneum found thickened and cedematous. Adhesions sprinkled with tubercles united the folds of the broad ligaments. The cavity was irrigated with boracic acid solution, iodoform was sprinkled upon the peritoneum, a drainage-tube was applied and the wound sutured. This operation was followed by complete success, the patient going home cured in six weeks. Twenty cases of abdominal section for tubercular peritonitis have been reported in children from two to fifteen years of age. All resulted in apparent cures.

May 21, 1892.

Periscope.

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PERTUSSIS.

Dr. Hallet says that under the influence of ozone inhalations lasting a quarter of an hour each day, the number of attacks diminishes, the general condition improves, and the appetite returns in a few days. Dr. Chibret claims that by sprinkling powdered iodoform over the pillow on which the child sleeps, the attacks of coughing are quickly arrested. Dr. Galvagno employs the following formula:

R Resorcin, 55 gr. xv.
 Antipyrin, gtt. x.
 Acid. hydrochloric, f 3 j.
 Syr. simp., f 3 ij. M.
 Aque dest., f 3 ij.
 Sig.—Three to five teaspoonfuls daily.

The average duration of cases thus treated does not exceed fifteen days. Dr. Noevius advises an infusion of thyme (100 to 700 parts water), to which are added fifty parts of syrup of marshmallow, and of this from a teaspoonful to a dessert-spoonful is given eight or ten times a day, according to the age of the child.—*Bul. Gen. de Therapeutique*, November, 1891.

Ungar, after six years' experience with quinine in the treatment of whooping-cough, is convinced that this remedy will moderate the violence and shorten the duration of this affection. Failures heretofore are due to the administration of too small doses. One and a half grains for every year of age up to four should be given three times daily, and the drug continued in small doses for several days after the paroxysms cease. He prefers the hydrochlorate, administered to young children in aqueous solution, with a few drops of muriatic acid, and flavored with raspberry syrup. Capsules may be given to older children, and should always be followed by a draught of an acidulated solution.—*Weiner Med. Wochen.*, 1891, No. 18.

THE TONGUE IN SCARLATINA.

Neumann (*Deutsche med. Zeitung* 1891, No 63, p. 715) states that in this disease the tongue passes through three stages of change: 1. Tumefaction of the mucous membrane with disturbance of the epithelium; 2. Desquamation; 3. Regeneration of the desquamated epithelium. The appearance of the characteristic "strawberry" tongue is caused, as is well known, by the swelling of the filiform and fungiform papillae deprived of their epithelium. Of 48 patients examined for this symptom,

the "strawberry" tongue was found in 38 (79 per cent.) in 4 the tongue was in one of the three stages mentioned above; while in 6 no modification was observed. Dyspeptic troubles precursory to the disease often so modify the tongue that the mucous membrane shows no new modification under the influence of the exanthem. The "strawberry" tongue was observed to last for one day in 3 cases; two days in 5 cases; three days in 6; four days in 4; and more than four days in the other 20 cases. It appeared during the first three days in 32 per cent. of the cases, and upon the fourth day in 68 per cent. The intensity of the cutaneous eruption seemed to bear no relation to the modifications of the tongue.

CONGENITAL BALDNESS AND PEMPHIGUS.

Bar (*Arch. de Tocol. et d'Obstet.*, December, 1891) has had a case of a child born with circular patches of baldness on the hairy scalp and a bulla of the character of pemphigus on the right hand. The suggestion is made that the bald spot may be pemphigus in its late stage, rarely seen, however, after birth, on the head. There was talipes, and the pregnancy was rendered more difficult by hydramnios. A syphilitic history could not be elicited.—*British Medical Journal*, February 6, 1892.

HYGIENE.

TYPHOID AND SALADS.

At a time when the profession is interested in discovering every channel through which the poison of enteric fever may be communicated, I should like to call attention to a mode of contagion which has generally escaped notice. We all know the peril of drinking water which has been in the slightest degree contaminated by sewage, but do we realize the danger of eating salads which during their growth have been irrigated by the market gardener with liquid manure? I chanced two years ago to observe a gardener bearing a long-spouted can in his hand, from which he poured two or three ounces of a brown evil-smelling fluid upon or round a row of young lettuce plants. Inquiring the source of this fluid, I was informed that it came from a neighboring cess-pool. Being a constant eater of salads, this little incident caused me to meditate, and also

to make further investigation from other gardeners as to the culture and bringing up of salad plants, and I discovered that it is usual for fluid composts to be thus used, wherever they can be obtained, to encourage the growth of lettuce, endive, celery, and similar vegetables. In the course of this frequent affusion with sewage it must happen that portions of the fluid fall upon the plant itself and percolate between its leaves. The watery portion will be absorbed or will evaporate, meanwhile the close circles of flattened stems and leaves of a celery or lettuce plant form a trap or filter which will hold and retain all solid particles such as the bacilli and other solid contagion of enteric fever, if any be present.

The gardener, of course, never thinks of inquiring into the source of his liquid manure; it is no part of his business to consider whether enteric fever has existed in any adjacent cottage which drains into his cess-pool or manure pond. Thus it may happen that the householder who has strictly guarded his water supply and his drainage from all possibility of enteric contagion, has lettuce or celery plants brought into his house which carry disease and death hidden within their delicate white leafage. Whether he and his family are poisoned or not may now depend upon the washing the vegetable receives. It is not easy to cleanse celery and lettuce in such a manner as to remove all solid particles, if such exist, from the close-gathered leaves about the heart of the plant; moreover, not one cook in fifty knows the importance of thorough washing. Since discovering the above facts I rarely eat any salad which is not grown in my own garden, and dressed by a cook who knows the perils of imperfect washing, but I always contemplate other salads with interest, and I have repeatedly discovered in them minute scraps of decaying organic matter, apparently derived from the market gardener's liquid manure can.

One meets occasionally with cases of enteric fever the origin of which is difficult to ascertain. I must confess I have never yet been able to prove contagion from this source, but the difficulty of such proof is overwhelming—to trace back the lettuce a patient consumed a fortnight ago to its birthplace in some French or English country garden, and to ascertain whether typhoid existed in the vicinity, passes the

wit of man. I have, however, had grave reason to suspect such an origin in certain cases where every other cause seemed excluded—it is evidently possible. I should like to know if any of your readers agree with me in the opinion I have expressed, and, if so, I feel strongly that the public ought to be warned of the danger.—*British Medical Journal*.

HOT BATHING IN JAPAN.

In hygienic matters the Japanese have everywhere a habit which may have a lesson for us. In their nightly bath and morning wash the water is never cold, never warm, but always as hot as it can be borne. To foreigners this habit seems very surprising, but the most inveterate Englishman, if he stays in the country long enough, abandons his cold tub in its favor. The cold-taking which it is suspected must follow it is found not to occur if the water has been hot enough. This heat is maintained by a little furnace beneath the bath. In the bath the bather or bathers take a prolonged soaking, the washing proper being done on the bath-room floor; then follows a second and final soaking, drying with towel, and a lounge in bathing wrapper. This habit seems to promote softness and suppleness of the skin, and by persons inclined to rheumatism is soon found to be altogether preferable to the cold bath in every particular. The poorest of the Japanese hear of a cold bath with amazement, and would be sure the man who used it must be a barbarian. With respect to the superiority of the hot bath over the cold, I have come to find that in my own case certainly the Japanese are right.—DR. BENJAMIN HEWARD, in the *Lancet*, January 16, 1892.

MEDICAL CHEMISTRY.

A PERMANENT FEHLING'S SOLUTION.

Fehling's solution by the usual formula is quite unstable. The following modification is suggested by Rossel in *Schweiz. Wochenschr.*: 34.56 grains pure cupric sulphate are dissolved in some distilled water; 150.0 grams glycerin and 130.0 grams caustic potassa and then made up to one litre. One c. cm. of this solution corresponds to 5 mg. of glucose. The solution is said to be a permanent one.

TYLOPHORINE, A NEW EMETIC.

Mr. Hooper has extracted from the root of the *Tylophora asthmatica*, a plant of the family *Asclepiadeae*, growing in East India, an alkaloid to which he has given the name tylophorine. The root has long been used in India as a sure and harmless emetic, and the new alkaloid is expected to have highly emetic properties. Tylophorine is crystalline, slightly soluble in water, but soluble in alcohol and ether. With hydrochloric and nitric acids it forms crystalline salts, which are readily soluble in water.

ALBUMIN TEST FOR URINE.

Dr. E. Speigler suggests the following: Mercuric chloride, 8.0; tartaric acid, 4.0; sugar, 20.0; water, 200 c. cm., as the reagent. Some urine is acidulated with strong acetic acid and filtered. Into a test-tube half filled with the reagent and behind which is placed a piece of black paper, add the urine so it will float on the reagent. If the albumin be only one part in 50,000, either at once or within one minute there will be produced a white ring at the surface of contact.

GLYCERITE OF IODIDE OF IRON.

Within a few months past an English writer brought forward a formula commending this as an improvement for permanency over the use of syrup of the pharmacopœia. A comment was made in our pages that the glycerite was made and dispensed by the editor while a clerk in 1858, and subsequently in his own business established that year. He did not claim that he was the originator of the preparation, for he was not, but the name of the person who had introduced it he could not then remember. It has since recurred to his mind—James O. Leamy, a graduate of the Philadelphia College of Pharmacy, who in 1857 and 1858 was a clerk with W. J. Oliffe at 809 Broadway.

NEWS AND MISCELLANY.

VISITING NURSE SOCIETY OF PHILADELPHIA.

The following cases are cited as illustrations of its work:—One Sunday, a man applied for help not knowing where else

to turn. He is an independent American, but what could he do? His wife lay very ill with typhoid fever, his children were mere babies, two, four and six years old, the only relative able to assist him was his mother, who could not reach him for two weeks. After a period of idleness he had just secured work in the Pennsylvania Railroad shops, but that would be lost if he could not be regular in his attendance. He had been forced to spend all his small savings, but promised to pay what he could spare from present earnings. With our "Special Fund" money, we sent him a woman to help with the care of the wife and children until his mother should arrive. A Visiting Nurse also gave daily attention, not only to his wife, but also to his child who was found to be suffering from a neglected attack of croup. It was too late to save this life, but the mother soon began to improve, and the nurse carried daily some of the nourishing food so kindly provided for us by the ladies, who all winter long take turns in sending diet for their patients.

One day recently the nurse was sent to a woman, ill and alone, except for a small dog. At first all offers of help were refused, but by degrees the nurse won her way and learned a sad story of a deserted life, wrecked by the misdeeds of others. In time the necessary cleanliness spread over the patient and her surroundings, even the dog improved and grew more cheerful. There was no one else in the house, but its owner came daily and was kind to the lonely inmate. One afternoon, when the nurse had washed her patient, combed her hair, tidied the room and cooked some oysters to leave behind her the distrustful air softened, and a few earnest words of gratitude were spoken. By the next morning death had come, and the poor little dog lay faithfully watching his silent mistress.

All the cases are not so sad as these. There is often an old woman living alone, and growing more and more infirm until she finds, to her distress, that she can no longer attend to her own cleanliness. At first she distrusts the Visiting Nurse and will almost rudely repel the offered service. By degrees the patient kindness has its effect, and it will be found that the weekly or semi-weekly visit is eagerly awaited, and that from the small pension or the careful savings of years, the nurse

must take her car fare and be urged to accept a trifling present.

An old lady living with her nephew and his family is one of the cases where the nurse's visit brings daily pleasure. Miss L. is becoming too infirm to go down stairs and while the family are kind to her, still there is no one who can attend to her as she now requires. She pays the carfare for each daily visit and thanks the nurse warmly for the sense of comfort she leaves behind her. The patient sent a sum of money to the Society on its Donation Day.

Then there are the babies, such a lot in one year! pretty little Russian Jews with the rich color in their cheeks, bright eyed children of Africa, Italians with now and then a Madonna-like mother, and the funny twins which always seem to enjoy the double trouble and fuss they make. Fancy twins in a household where the mother proudly displays only one entire suit of baby clothing in preparation for the event. What should we do in such a case without the help of the small bundles given by King's Daughters, the Needle-work Guild, etc.

Often a mother speaks gratefully to the nurses after ten days care, telling them how much better and stronger she feels than ever before after such a period, for their care has saved her strength and prevented any of the complications common in neglected cases.

Those of us who have known the comfort of trained nurses, who have felt perhaps, that precious lives depended on their care, surely can give generous support to send similar help to our poorer neighbors.

AMERICAN SURGICAL ASSOCIATION

The Association will meet in Boston, Mass., Tuesday morning, May 31st, and June 1st and 2d, 1892, in the hall of the Natural History Society on Berkeley street.

Special Subjects for Discussion.—1.

"The Treatment of Uncomplicated Fractures of the Lower End of the Humerus

and of the Base of the Radius," by John B. Roberts, M.D., Philadelphia, Pa. 2. "Fibroid Tumors of the Uterus," by John Homans, M.D., Boston, Mass. 3. "Surgical Operations in Persons Suffering from Diseases not Connected with that Necessitating the Operation, such as Chronic Malarial Poisoning, Diabetes, Organic Heart Disease, etc.," by W. T. Briggs, M.D., Nashville, Tenn. 4. "Surgery of the Tongue," by N. P. Dandridge, M.D., Cincinnati, Ohio. 5. "Conditions Demanding Excision of the Globe of the Eye," by W. H. Carmalt, M.D., New Haven, Conn. 6. "Ancient Contractures of the Hip and Knee Joints," by T. F. Prewitt, M.D., St. Louis, Mo. 7. "Report of Operations upon Spina Bifida and Encephalocoele, with Remarks." By A. T. Cabot, M.D., Boston, Mass.

PHINEAS S. CONNOR, *President.*

J. R. WEIST, *Secretary.*

A CLEAR STATEMENT:

Being a brief summary, from the notebook of an undergraduate, of a lecture on tuberculosis by a professor of liberal but uncertain opinions.

The microbe of consumption that Koch has hunted out,

I beg to say we know most clear and plainly all about.

And I myself, as you all know, have always held it wise

To tell at once what knowledge new pathology supplies.

And so I wish to state, with no periphrasis or doubt, Bacillus' source, course, consequence, within us and without.

This troublesome bacillus *perhaps* may—might be—cause

Of phthisis—or might not be—our logic has such flaws!

This troublesome bacillus, a most annoying kind, In various herbivora, as well as man, we find,

But, whether really dangerous, as modified by cow—I—well—I'd really rather not state definitely how.

The question of contagion, too, a most important one;

I'm nearly, quite, almost convinced the thing cannot be done.

Each wavering pathologist has views as yet quite dim,

And how can we clinicians be more accurate than him!

Therefore, I think (as I have said)—that is—I should suppose—

The tubercle-bacillus is—oh!—everybody knows!

K—